Federally Qualified Health Center
WRAP Supplemental Payment
Reference Guide

(April 2016)

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WRAP Supplemental Payment Process Overview

A Medicaid Eligible patient who is assigned to a Managed Care Organization (MCO) is provided services by an FQHC.

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The FQHC bills the MCO for the services provided to the patient and is reimbursed the contracted amount from the MCO.

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The FQHC gathers all such claims for the time period being submitted (quarterly, monthly) and submits the data to DHCFP.

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DHCFP calculates how many encounters the FQHC provided to eligible members in the time period. This is used to calculate the total PPS rate due to the FQHC. DHCFP then deducts the amounts already paid by the MCO from the total PPS rate.
The balance is the WRAP Supplemental Payment.

Example: 1. FQHC submits a file containing 1000 encounters.
In this example, The FQHC's PPS rate is $138.50 per encounter.

2. The total PPS rate due is $138,500.00 (1000 x $138.50 each)

3. The MCO amount already paid on those encounters is $65,000.00.

The WRAP payment is calculated:

PPS Rate: $138,500.00 (1000 encounters x $138.50 each)
Less
MCO Paid: $65,000.00 (Total of Amounts already paid on the encounters)

WRAP: $73,500.00 (WRAP Supplemental Payment)

c. **Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)**

FQHC and RHC reimbursement will adhere to section 1902(a) of the Social Security Act as amended by Section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA). The reasonable cost-based reimbursement requirements for FQHC/RHC services previously described at paragraph (13) (C) are repealed and instead a Prospective Payment System (PPS) consistent with paragraph (15) payment described in section 1902(aa) of the Act for FQHCs/RHCs will be implemented. The Nevada Medicaid Prospective Payment System (PPS) is to take effect on January 1, 2001.

Prospective Payment System (PPS) Reimbursement for Existing Facilities

Beginning January 1, 2001 the State will pay current FQHCs/RHCs (including "FQHC look alike clinics") based on a PPS. The baseline for a PPS will be set at 100 percent of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid covered services during the FQHC/RHC fiscal years 1999 and 2000, adjusted to take into account any reported increase (or decrease) in the scope of services furnished during FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Medicaid-covered services that are considered to be FQHC/RHC services are those services that were identified and approved to be provided by the facility as it applies to HRSA in order to be deemed as an FQHC/RHC facility.

Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous year, increased each October 1st (FFY) by the percentage increase in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (4) of the Social Security Act, and adjusted to take into account any reported increase (or decrease) in the scope of services furnished by the FQHC/RHC during that fiscal year.

Prospective Payment System (PPS) Reimbursement for New Facilities

Newly qualified FQHCs/RHCs after Federal fiscal year 2000 will have initial payments (interim rate) established either by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads and/or similar scope of services or based on an average of rates for other FQHC/RHC clinics throughout the State. Once their average per visit reasonable costs of providing Medicaid-covered services based on their first full year of operation can be determined, the initial payments of the FQHC/RHC will be cost settled and any over or under payments will be determined and the PPS rate will then be established based on actual cost to provide those services for their first full year. The per visit PPS rate will then be adjusted annually every October 1st beginning at the next federal fiscal year by the percentage change in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (4) of the Social Security Act, for that calendar year as published in the Federal Register, adjusted to take into account any reported change in scope of services, reported and requested during that year. All required documentation of actual costs for the first full year of providing services must be furnished to DHCFP no later than six (6) months after completion of the first full year of services. If the required documentation is not received within six (6) months after the completion of a full year of services, the annual MEI adjustments will be suspended until such time as the documentation is received and an actual PPS rate is determined.

Rebasing: Baseline PPS rates will not be subject to rebasing after their initial computation unless authorized by congress. The actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment to the baseline PPS rate will be made.

Alternative Payment Methodology (APM) Reimbursement

For the period beginning January 1, 2001 and ending September 30, 2001, and for any fiscal year beginning with FY 2002, a State may, in reimbursing an FQHC/RHC for services furnished to Medicaid beneficiaries, use a methodology other than the Medicaid PPS, but only if the following statutory requirements are met. First, the APM must be agreed to by the State and by each individual FQHC/RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is a least equal to the amount to which the center or clinic is entitled under the Medicaid PPS. Third, the methodology must be described in the approved State plan.

Effective October 1st (FFY) of each year after an APM rate has been established, for services furnished on or after that date, DHCFP will adjust the APM rate by the percentage increase in the MEI applicable to primary care services as published in the Federal Register for that calendar year, which will account for basic cost increases associated with providing such services.

Change in Scope of Services

PPS/APM rates may be adjusted to take into account any requested, documented and approved increase (or decrease) in the scope of services furnished by the FQHC/RHC in any given fiscal year. The FQHC/RHC must submit a written request to the Division within 60 days of the effective date of those changes in order for the rate adjustment to be retroactive to the date of the Change in Scope of Services. If a written request is not received within 60 days of those changes, the effective date for a rate adjustment will be the date the written request for a Change in Scope of Services was received by DHCFP. Documentation and notification to support an increase or decrease in the scope of services is the responsibility of the provider.

An FQHC/RHC requesting a rate adjustment for changes in scope of services must submit data/documentation/schedules that substantiate the changes in scope and the related adjustment of reasonable costs following Medicare principals of reimbursement.

An interim rate will be determined using the first three months of actual cost data available from the provider. After a full year of providing the services related to the change in scope, an analysis will be performed on the actual costs for a full year of service and an adjustment will be made to the PPS/APM. Adjustments to the PPS/APM rate for qualified/approved changes in scope will be based on Medicare Cost Reimbursement methodology, allocating costs related to patient care based upon a providers audited and approved charges for the change in scope services. The PPS/APM rate adjustment will then be determined by dividing the Medicaid allocated costs by the number of Medicaid visits for the given
time period.

A Change in Scope of Services has been defined as a change in the type, intensity, duration and/or amount of covered Medicaid services (covered under the Medicaid State Plan and approved by CMS) that meet the definition of FQHC/RHC services as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act. General increases or decreases in costs associated with programs that were already a part of an established PPS/APM rate do NOT constitute a Change in Scope unless all of the following requirements are met:

- The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act.
- The cost is allowable under Medicare reasonable cost principals set forth in 42CFR Part 413.
- The net change in the FQHC/RHC's per visit rate must equal or exceed 4% for the affected FQHC/RHC site. For FQHC/RHC's that filed consolidated cost reports for multiple sites to establish the initial Prospective Payment reimbursement rate (PPS), the 4% threshold will be applied to the average per visit rate of all sites for the purposes of calculating the cost associated with a scope of service change. "Net change" means the per visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

A Change in Scope of Services includes any of the following:

- A change in the types of services offered, i.e., the addition of dental services, may qualify as a Change in Scope which may warrant an adjustment to the PPS/APM rate.
- A change in intensity/duration or character of services offered by an FQHC/RHC attributable to changes in the types of patients served may qualify, such as services to patients with HIV/AIDS or other chronic diseases and other special populations requiring more intensive and frequent care.
- A change in the magnitude, intensity or character of currently offered services, demonstrated and documented by an increase or decrease in the patient volume of certain high risk populations that require more intensive and frequent care, which may reasonably be expected to span at least one year may qualify.
- A change in the type, intensity, duration or amount of service caused by changes in technology and medical practice used may qualify.

Definition of a "Visit"/"Encounter"

A "visit" or an "encounter" for the purposes of reimbursing FQHC/RHC services is defined as face-to-face contact with one or more qualified health professionals and multiple contacts with the same health professional that take place on the same day with the same patient. A single payment will be made for each "visit" or an "encounter" regardless of the type of service.

Qualified Health Professional

To be eligible for PPS/APM reimbursement, services must be delivered exclusively by one or more of the following licensed Qualified Health Professionals or a provider working under his or her direct supervision: physician, physician's assistant, nurse practitioner, nurse anesthetist, nurse midwife, clinical psychologist, clinical social worker, dentist or dental hygienist.

Documentation Required to Support a Request for Change in Scope of Services

- Year End Payroll Reports for identified time periods
- Trial Balances for all Revenues and Expenses for identified time periods
- Grouping Schedule/Mapping of Trial Balance Accounts to the Cost Reports
- Detailed General Ledger with Vendor Information for identified time periods
- HRSA Notice of Awards for all approved Changes in Scope of Services
- Claims reports showing Unique Patient Visits, DOS, Procedure Codes, Service Facility ID#, Amount Paid and Payor
- Other Items as Deemed Necessary

Other Payment Adjustments

FQHC/RHC's may request other payment adjustments in the event of extraordinary circumstances, not otherwise reimbursed by other sources, including but not limited to acts of God; acts of nature; acts of terrorism and acts of war. However, if an FQHC/RHC's existing PPS/APM rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, other payment adjustment is not warranted. The FQHC/RHC must show that its PPS/APM rate is not sufficient to cover the costs associated with the extraordinary circumstance. The adjusted rate will only apply to the extent, and only for the period of time, that the additional costs for the event are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation (FMAP). DHCFP will work with the provider to gather the appropriate data at the time the incident occurs and a written request for a rate adjustment is made by the Provider.

Record keeping and Audit

All participating FQHC/RHC's shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles and must maintain documentation sufficient to support all cost/visit data. The DHCFP, its fiscal agent or a designated and contracted financial entity may conduct periodic on-site or desk audits of all cost data, including financial and statistical records of the FQHC/RHCs.

FQHC/RHCs must submit information (statistics, costs and financial data or other data) as deemed necessary by the DHCFP or its fiscal agent. Failure to submit requested documentation may result in denial of a rate adjustment request.

The DHCFP will conduct one audit annually (at a minimum) to the claims submitted by the FQHC/RHC for supplemental payments.

Supplemental Payments for FQHCs/RHCs

FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly or monthly (as agreed upon between the provider and the state) supplemental payments for furnishing such services, that are a calculation of the difference between the payments the FQHC/RHC receives from the MCE(s) for all qualified Medicaid visits and the payments the FQHC/RHC would have received under the BIPA PPS methodology or APM.

At the end of each payment period, the total amount of MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the PPS/APM methodology. If the amount exceeds the total amount of MCE payments, the FQHC/RHC will be paid the difference, if the amount is less, the FQHC/RHC will refund the difference to DHCFP. The FQHC/RHCs must provide sufficient documentation (as requested) to DHCFP to facilitate supplemental payment calculations. If the required documentation is not provided to support the supplemental payment, future supplemental payments may be suspended.

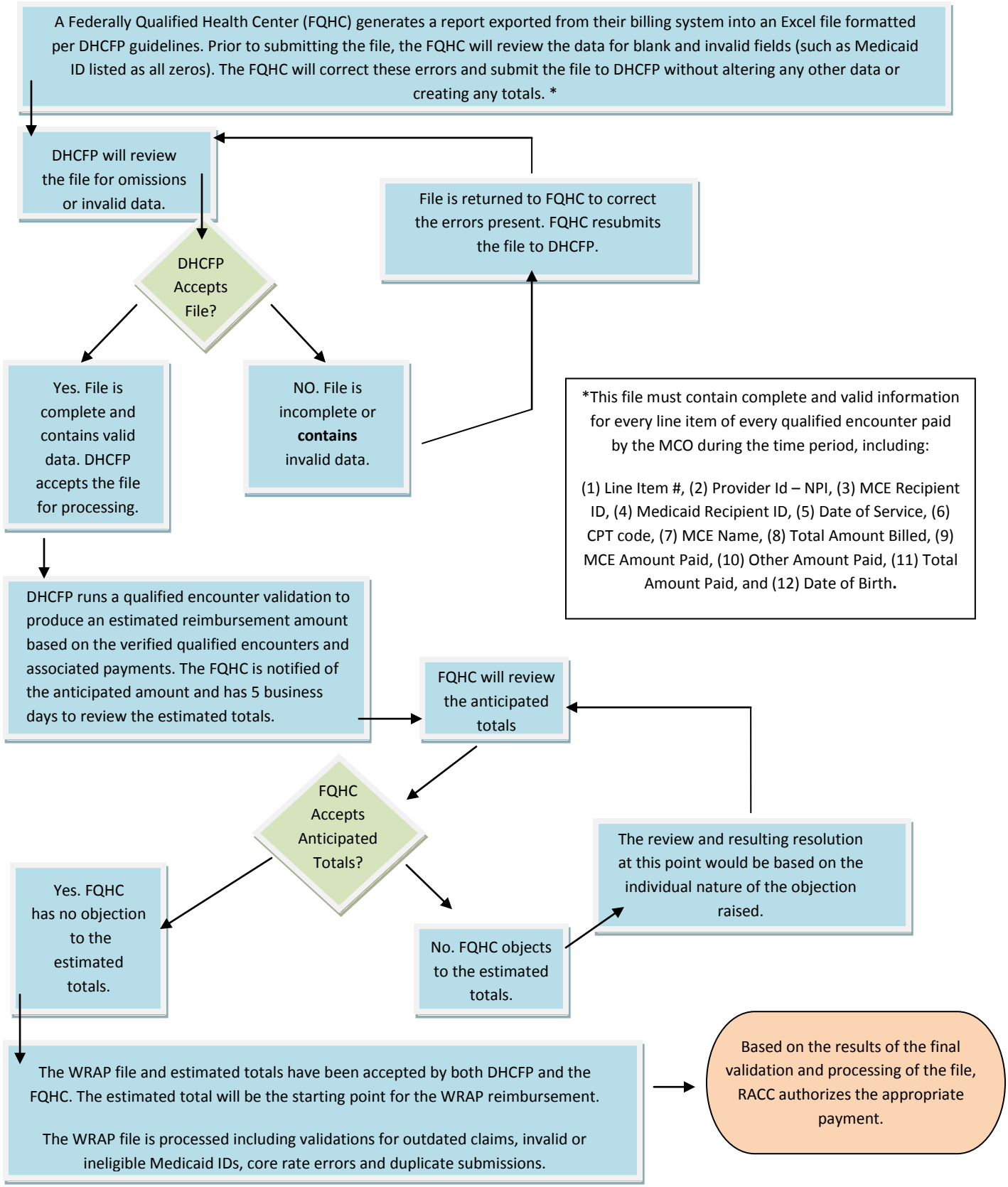
Documentation Required to Calculate/Support Supplemental Payments

The FQHC/RHC will submit a written/electronic request for supplemental payment which will contain at least the following information for each line item of every qualified encounter during the reporting time period (Quarterly or Monthly): Servicing and Billing Provider ID#s, Recipient MCE ID Number, Recipient Medicaid ID Number, Date of Service, CPT Code(s), MCE Name, Total Billed Amount, MCE Paid Amount, Other Paid Amount and Total Amount Paid.

The FQHC/RHC will submit claim data for supplemental payment no later than thirty days after the end of the reporting period agreed upon with the DHCFP (Quarterly or Monthly).

Any discrepancy found in the audits will be adjusted based on the audit findings.

DHCFP – Reimbursement, Analysis and Payment (RAP)
WRAP Supplemental Payment Submission Process



Medical WRAP Supplemental Payment
Guidelines April 2016

In an effort to fully reflect the Medicaid policy related to the submission, processing and payment of supplemental Medical WRAP claims, the following guidelines will be effective January 1, 2016:

1. The data submitted for supplemental payment will contain only raw data, exported from the FQHC's billing system into an Excel file following the guidelines below. The FQHC will not make any calculations to the data submitted. The following information is required for all line items of all qualified medical encounters submitted for supplemental payment:

(The corresponding Excel format required for each item is listed to the right)

	ITEM	FORMAT
a.	Line Item #	Number (NBR) –(No Formulas or Macros)
b.	Provider ID (NPI)	Text (TX)
c.	MCE Recipient ID	Text (TX)
d.	Medicaid Recipient ID*	Text (TX)
e.	Date of Service	Date (mm/dd/yyyy)
f.	CPT code	Text (TX)
g.	MCE Name	Text (TX)
h.	Total Amount Billed	Currency ($)
i.	MCE Paid Amount	Currency ($)
j.	Other Paid Amount	Currency ($)
k.	Total Paid Amount	Currency ($)
l.	Date of Birth	Date (mm/dd/yyyy)

**The Medicaid Recipient ID must be 11 digits (characters) long. Leading zeros must be manually typed in if not present. It is important to ensure this number remains in text format. The Medicaid Recipient ID must be a valid ID (11 zeros is invalid data).*

Files that contain invalid or incorrect information will be returned to the FQHC for corrections.

2. RAP will run the revised validation process over the raw data submission and calculate the expected reimbursement based on the results. Once these validations are completed by RAP, the FQHC will be notified of the resulting totals and will have five (5) business days to review the data.

3. After five (5) business days or upon notification from the FQHC to proceed, RAP will finish validation and processing of the WRAP data and authorize the appropriate supplemental payment to the FQHC.

Dental WRAP Supplemental Payment
Guidelines January 1, 2016

In an effort to fully reflect the Medicaid policy related to the submission, processing and payment of supplemental Dental WRAP claims, the following guidelines will apply to all claims submitted after January 1, 2016

1. The data submitted for supplemental payment will contain only raw data, exported from the FQHC's billing system into an Excel file following the guidelines below. The FQHC will not make any calculations to the data submitted. The following information is required for all line items of all qualified dental encounters submitted for supplemental payment:

(The corresponding Excel format required for each item is listed to the right)

	ITEM	FORMAT
A.	Line Item #	Number (NBR) –(No Formulas or Macros)
B.	Provider ID (NPI)	Text (TX)
C.	MCE Recipient ID	Text (TX)
D.	Medicaid Recipient ID*	Text (TX)
E.	Date of Service	Date (mm/dd/yyyy)
F.	CDT code	Text (TX)
G.	MCE Name	Text (TX)
H.	Total Amount Billed	Currency ($)
I.	MCE Paid Amount	Currency ($)
J.	Other Paid Amount	Currency ($)
K.	Total Paid Amount	Currency ($)
L.	Recipient Date of Birth	Date (mm/dd/yyyy)

**The Medicaid Recipient ID must be 11 digits (characters) long. Leading zeros must be manually typed in if not present. It is important to ensure this number remains in text format. The Medicaid Recipient ID must be a valid ID (11 zeros is invalid data).*

Files that contain invalid or incorrect information will be returned to the FQHC for corrections.

2. RAP will run the revised validation process over the raw data submission and calculate the expected reimbursement based on the results. Once these validations are completed by RAP, the FQHC will be notified of the resulting totals and will have five (5) business days to review the data.

3. After five (5) business days or upon notification from the FQHC to proceed, RAP will finish validation and processing of the WRAP data and authorize the appropriate supplemental payment to the FQHC.

VALID ENCOUNTER CPT/CDT CODE LIST

Valid E&M Codes for Qualified Encounters	Description
10060	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENITIS,
10061	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENITIS,
10080	INCISION AND DRAINAGE OF PILONIDAL CYST; SIMPLE
10120	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; SIMPLE
10121	INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; COMPLICATED
10140	INCISION AND DRAINAGE OF HEMATOMA, SEROMA OR FLUID COLLECTION
10160	PUNCTURE ASPIRATION OF ABSCESS, HEMATOMA, BULLA, OR CYST
10180	INCISION AND DRAINAGE, COMPLEX, POSTOPERATIVE WOUND INFECTION
11000	DEBRIDEMENT OF EXTENSIVE ECZEMATOUS OR INFECTED SKIN; UP TO 10% OF BODY SURFACE
11004	DEBRIDEMENT OF SKIN, SUBCUTANEOUS TISSUE, MUSCLE AND FASCIA FOR NECROTIZING
11042	DEBRIDEMENT, SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS, IF PERFORMED);
11045	DEBRIDEMENT SUBCUTANEOUS TISSUE (INCLUDES EPIDERMIS AND DERMIS IF PERFORMED);
11046	DEBRIDEMENT MUSCLE AND/OR FASCIA (INCLUDES EPIDERMIS DERMIS AND SUBCUTANEOUS
11047	DEBRIDEMENT BONE (INCLUDES EPIDERMIS DERMIS SUBCUTANEOUS TISSUE MUSCLE
11055	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); SINGLE
11056	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); 2 TO 4
11057	PARING OR CUTTING OF BENIGN HYPERKERATOTIC LESION (EG, CORN OR CALLUS); MORE
11100	BIOPSY OF SKIN, SUBCUTANEOUS TISSUE AND/OR MUCOUS MEMBRANE (INCLUDING SIMPLE
11101	BIOPSY OF SKIN, SUBCUTANEOUS TISSUE AND/OR MUCOUS MEMBRANE (INCLUDING SIMPLE
11200	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; UP TO AND
11201	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; EACH ADDITIONAL
11300	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS;
11301	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS;

Valid E&M Codes for Qualified Encounters	Description
11302	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS;
11303	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS;
11305	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET,
11306	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET,
11307	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET,
11310	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS,
11311	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS,
11312	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS,
11400	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11401	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11402	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11403	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11404	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11406	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11420	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11421	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11422	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11423	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11424	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11440	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11441	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11442	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11443	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11444	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED

Valid E&M Codes for Qualified Encounters	Description
11600	EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS, OR LEGS; EXCISED
11601	EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS, OR LEGS; EXCISED
11602	EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS, OR LEGS; EXCISED
11603	EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS, OR LEGS; EXCISED
11604	EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS, OR LEGS; EXCISED
11620	EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK, HANDS, FEET,
11621	EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK, HANDS, FEET,
11622	EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK, HANDS, FEET,
11623	EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK, HANDS, FEET,
11624	EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK, HANDS, FEET,
11640	EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS, EYELIDS, NOSE, LIPS;
11641	EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS, EYELIDS, NOSE, LIPS;
11642	EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS, EYELIDS, NOSE, LIPS;
11643	EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS, EYELIDS, NOSE, LIPS;
11720	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 1 TO 5
11721	DEBRIDEMENT OF NAIL(S) BY ANY METHOD(S); 6 OR MORE
11730	AVULSION OF NAIL PLATE, PARTIAL OR COMPLETE, SIMPLE; SINGLE
11732	AVULSION OF NAIL PLATE, PARTIAL OR COMPLETE, SIMPLE; EACH ADDITIONAL NAIL PLATE
11740	EVACUATION OF SUBUNGUAL HEMATOMA
11750	EXCISION OF NAIL AND NAIL MATRIX, PARTIAL OR COMPLETE, (EG, INGROWN OR DEFORMED
11765	WEDGE EXCISION OF SKIN OF NAIL FOLD (EG, FOR INGROWN TOENAIL)
11770	EXCISION OF PILONIDAL CYST OR SINUS; SIMPLE
11900	INJECTION, INTRALESIONAL; UP TO AND INCLUDING 7 LESIONS
11901	INJECTION, INTRALESIONAL; MORE THAN 7 LESIONS
11976	REMOVAL, IMPLANTABLE CONTRACEPTIVE CAPSULES
11981	INSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT

Valid E&M Codes for Qualified Encounters	Description
11982	REMOVAL, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11983	REMOVAL WITH REINSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
12001	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL
12002	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF SCALP, NECK, AXILLAE, EXTERNAL
12011	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR
12013	SIMPLE REPAIR OF SUPERFICIAL WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR
12020	TREATMENT OF SUPERFICIAL WOUND DEHISCENCE; SIMPLE CLOSURE
12031	REPAIR, INTERMEDIATE, WOUNDS OF SCALP, AXILLAE, TRUNK AND/ OR EXTREMITIES
12032	REPAIR, INTERMEDIATE, WOUNDS OF SCALP, AXILLAE, TRUNK AND/ OR EXTREMITIES
12034	REPAIR, INTERMEDIATE, WOUNDS OF SCALP, AXILLAE, TRUNK AND/ OR EXTREMITIES
12041	REPAIR, INTERMEDIATE, WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA;
12042	REPAIR, INTERMEDIATE, WOUNDS OF NECK, HANDS, FEET AND/OR EXTERNAL GENITALIA;
12051	REPAIR, INTERMEDIATE, WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS
12052	REPAIR, INTERMEDIATE, WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS
12053	REPAIR, INTERMEDIATE, WOUNDS OF FACE, EARS, EYELIDS, NOSE, LIPS AND/OR MUCOUS
16000	INITIAL TREATMENT, FIRST DEGREE BURN, WHEN NO MORE THAN LOCAL TREATMENT IS
16020	DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS, INITIAL OR SUBSEQUENT;
16025	DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS, INITIAL OR SUBSEQUENT;
16030	DRESSINGS AND/OR DEBRIDEMENT OF PARTIAL-THICKNESS BURNS, INITIAL OR SUBSEQUENT;
17000	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY,
17003	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY,
17004	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY,
17110	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY,
17111	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY,

Valid E&M Codes for Qualified Encounters	Description
17250	CHEMICAL CAUTERIZATION OF GRANULATION TISSUE (PROUD FLESH, SINUS OR FISTULA)
17260	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY,
17261	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY,
17262	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY,
17270	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY,
17271	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY,
17272	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY,
17280	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY,
17281	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY,
17282	DESTRUCTION, MALIGNANT LESION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY,
19000	PUNCTURE ASPIRATION OF CYST OF BREAST;
19100	BIOPSY OF BREAST; PERCUTANEOUS, NEEDLE CORE, NOT USING IMAGING GUIDANCE
20520	REMOVAL OF FOREIGN BODY IN MUSCLE OR TENDON SHEATH; SIMPLE
20525	REMOVAL OF FOREIGN BODY IN MUSCLE OR TENDON SHEATH; DEEP OR COMPLICATED
20526	INJECTION, THERAPEUTIC (EG, LOCAL ANESTHETIC, CORTICOSTEROID), CARPAL TUNNEL
20527	INJECTION, ENZYME (EG, COLLAGENASE), PALMAR FASCIAL CORD (IE, DUPUYTREN'S
20550	INJECTION(S); SINGLE TENDON SHEATH, OR LIGAMENT, APONEUROSIS (EG, PLANTAR
20552	INJECTION(S); SINGLE OR MULTIPLE TRIGGER POINT(S), 1 OR 2 MUSCLE(S)
20600	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; SMALL JOINT OR BURSA (EG, FINGERS,
20605	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; INTERMEDIATE JOINT OR BURSA (EG,
20610	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; MAJOR JOINT OR BURSA (EG,
20612	ASPIRATION AND/OR INJECTION OF GANGLION CYST(S) ANY LOCATION
20680	REMOVAL OF IMPLANT; DEEP (EG, BURIED WIRE, PIN, SCREW, METAL BAND, NAIL, ROD OR
21011	ARTHROTOMY, TEMPOROMANDIBULAR JOINT; BILATERAL

Valid E&M Codes for Qualified Encounters	Description
21012	EXCISION, TUMOR, SOFT TISSUE OF FACE OR SCALP, SUBCUTANEOUS; 2 CM OR GREATER
21013	EXCISION, TUMOR, SOFT TISSUE OF FACE AND SCALP, SUBFASCIAL (EG, SUBGALEAL,
21014	EXCISION, TUMOR, SOFT TISSUE OF FACE AND SCALP, SUBFASCIAL (EG, SUBGALEAL,
21073	MANIPULATION OF TEMPOROMANDIBULAR JOINT(S) (TMJ) THERAPEUTIC REQUIRING AN
21552	EXCISION, TUMOR, SOFT TISSUE OF NECK OR ANTERIOR THORAX, SUBCUTANEOUS; 3 CM OR
21554	EXCISION, TUMOR, SOFT TISSUE OF NECK OR ANTERIOR THORAX, SUBFASCIAL (EG,
21800	CLOSED TREATMENT OF RIB FRACTURE, UNCOMPLICATED, EACH
21931	EXCISION, TUMOR, SOFT TISSUE OF BACK OR FLANK, SUBCUTANEOUS; 3 CM OR GREATER
21932	EXCISION, TUMOR, SOFT TISSUE OF BACK OR FLANK, SUBFASCIAL (EG, INTRAMUSCULAR);
21933	EXCISION, TUMOR, SOFT TISSUE OF BACK OR FLANK, SUBFASCIAL (EG, INTRAMUSCULAR);
22901	EXCISION, TUMOR, SOFT TISSUE OF ABDOMINAL WALL, SUBFASCIAL (EG, INTRAMUSCULAR);
22902	EXCISION, TUMOR, SOFT TISSUE OF ABDOMINAL WALL, SUBCUTANEOUS; LESS THAN 3 CM
22903	EXCISION, TUMOR, SOFT TISSUE OF ABDOMINAL WALL, SUBCUTANEOUS; 3 CM OR GREATER
23071	EXCISION, TUMOR, SOFT TISSUE OF SHOULDER AREA, SUBCUTANEOUS; 3 CM OR GREATER
23073	EXCISION, TUMOR, SOFT TISSUE OF SHOULDER AREA, SUBFASCIAL (EG, INTRAMUSCULAR);
23500	CLOSED TREATMENT OF CLAVICULAR FRACTURE; WITHOUT MANIPULATION
23600	CLOSED TREATMENT OF PROXIMAL HUMERAL (SURGICAL OR ANATOMICAL NECK) FRACTURE;
23620	CLOSED TREATMENT OF GREATER HUMERAL TUBEROSITY FRACTURE; WITHOUT MANIPULATION
23650	CLOSED TREATMENT OF SHOULDER DISLOCATION, WITH MANIPULATION; WITHOUT ANESTHESIA
23930	INCISION AND DRAINAGE, UPPER ARM OR ELBOW AREA; DEEP ABSCESS OR HEMATOMA
24071	EXCISION, TUMOR, SOFT TISSUE OF UPPER ARM OR ELBOW AREA, SUBCUTANEOUS; 3 CM OR
24073	EXCISION, TUMOR, SOFT TISSUE OF UPPER ARM OR ELBOW AREA, SUBFASCIAL (EG,
24500	CLOSED TREATMENT OF HUMERAL SHAFT FRACTURE; WITHOUT MANIPULATION
24530	CLOSED TREATMENT OF SUPRACONDYLAR OR TRANSCONDYLAR HUMERAL FRACTURE, WITH OR

Valid E&M Codes for Qualified Encounters	Description
24560	CLOSED TREATMENT OF HUMERAL EPICONDYLAR FRACTURE, MEDIAL OR LATERAL; WITHOUT
24576	CLOSED TREATMENT OF HUMERAL CONDYLAR FRACTURE, MEDIAL OR LATERAL; WITHOUT
24650	CLOSED TREATMENT OF RADIAL HEAD OR NECK FRACTURE; WITHOUT MANIPULATION
24670	CLOSED TREATMENT OF ULNAR FRACTURE, PROXIMAL END (OLECRANON PROCESS); WITHOUT
25071	EXCISION, TUMOR, SOFT TISSUE OF FOREARM AND/OR WRIST AREA, SUBCUTANEOUS; 3 CM
25073	EXCISION, TUMOR, SOFT TISSUE OF FOREARM AND/OR WRIST AREA, SUBFASCIAL (EG,
25500	CLOSED TREATMENT OF RADIAL SHAFT FRACTURE; WITHOUT MANIPULATION
25530	CLOSED TREATMENT OF ULNAR SHAFT FRACTURE; WITHOUT MANIPULATION
25560	CLOSED TREATMENT OF RADIAL AND ULNAR SHAFT FRACTURES; WITHOUT MANIPULATION
25600	CLOSED TREATMENT OF DISTAL RADIAL FRACTURE (EG, COLLES OR SMITH TYPE) OR
25622	CLOSED TREATMENT OF CARPAL SCAPHOID (NAVICULAR) FRACTURE; WITHOUT MANIPULATION
25630	CLOSED TREATMENT OF CARPAL BONE FRACTURE (EXCLUDING CARPAL SCAPHOID
26010	DRAINAGE OF FINGER ABSCESS; SIMPLE
26110	ARTHROTOMY WITH BIOPSY; INTERPHALANGEAL JOINT, EACH
26111	EXCISION, TUMOR OR VASCULAR MALFORMATION, SOFT TISSUE OF HAND OR FINGER,
26113	EXCISION, TUMOR, SOFT TISSUE, OR VASCULAR MALFORMATION, OF HAND OR FINGER,
26341	MANIPULATION, PALMAR FASCIAL CORD (IE, DUPUYTREN'S CORD), POST ENZYME INJECTION
26600	CLOSED TREATMENT OF METACARPAL FRACTURE, SINGLE; WITHOUT MANIPULATION, EACH BONE
26720	CLOSED TREATMENT OF PHALANGEAL SHAFT FRACTURE, PROXIMAL OR MIDDLE PHALANX,
26750	CLOSED TREATMENT OF DISTAL PHALANGEAL FRACTURE, FINGER OR THUMB; WITHOUT
27043	EXCISION, TUMOR, SOFT TISSUE OF PELVIS AND HIP AREA, SUBCUTANEOUS; 3 CM OR
27045	EXCISION, TUMOR, SOFT TISSUE OF PELVIS AND HIP AREA, SUBFASCIAL (EG,
27267	CLOSED TREATMENT OF FEMORAL FRACTURE PROXIMAL END HEAD; WITHOUT MANIPULATION
27337	EXCISION, TUMOR, SOFT TISSUE OF THIGH OR KNEE AREA, SUBCUTANEOUS; 3 CM OR

Valid E&M Codes for Qualified Encounters	Description
27339	EXCISION, TUMOR, SOFT TISSUE OF THIGH OR KNEE AREA, SUBFASCIAL (EG,
27632	EXCISION, TUMOR, SOFT TISSUE OF LEG OR ANKLE AREA, SUBCUTANEOUS; 3 CM OR GREATER
27634	EXCISION, TUMOR, SOFT TISSUE OF LEG OR ANKLE AREA, SUBFASCIAL (EG,
27750	CLOSED TREATMENT OF TIBIAL SHAFT FRACTURE (WITH OR WITHOUT FIBULAR FRACTURE);
27760	CLOSED TREATMENT OF MEDIAL MALLEOLUS FRACTURE; WITHOUT MANIPULATION
27767	CLOSED TREATMENT OF POSTERIOR MALLEOLUS FRACTURE; WITHOUT MANIPULATION
27768	CLOSED TREATMENT OF POSTERIOR MALLEOLUS FRACTURE; WITH MANIPULATION
27780	CLOSED TREATMENT OF PROXIMAL FIBULA OR SHAFT FRACTURE; WITHOUT MANIPULATION
27786	CLOSED TREATMENT OF DISTAL FIBULAR FRACTURE (LATERAL MALLEOLUS); WITHOUT
27808	CLOSED TREATMENT OF BIMALLEOLAR ANKLE FRACTURE, (INCLUDING POTTS); WITHOUT
27816	CLOSED TREATMENT OF TRIMALLEOLAR ANKLE FRACTURE; WITHOUT MANIPULATION
28039	EXCISION, TUMOR, SOFT TISSUE OF FOOT OR TOE, SUBCUTANEOUS; 1.5 CM OR GREATER
28041	EXCISION, TUMOR, SOFT TISSUE OF FOOT OR TOE, SUBFASCIAL (EG, INTRAMUSCULAR);
28400	CLOSED TREATMENT OF CALCANEAL FRACTURE; WITHOUT MANIPULATION
28430	CLOSED TREATMENT OF TALUS FRACTURE; WITHOUT MANIPULATION
28450	TREATMENT OF TARSAL BONE FRACTURE (EXCEPT TALUS AND CALCANEUS); WITHOUT
28470	CLOSED TREATMENT OF METATARSAL FRACTURE; WITHOUT MANIPULATION, EACH
28490	CLOSED TREATMENT OF FRACTURE GREAT TOE, PHALANX OR PHALANGES; WITHOUT
28510	CLOSED TREATMENT OF FRACTURE, PHALANX OR PHALANGES, OTHER THAN GREAT TOE;
29065	APPLICATION, CAST; SHOULDER TO HAND (LONG ARM)
29075	APPLICATION, CAST; ELBOW TO FINGER (SHORT ARM)
29085	APPLICATION, CAST; HAND AND LOWER FOREARM (GAUNTLET)
29086	APPLICATION, CAST; FINGER (EG, CONTRACTURE)
29405	APPLICATION OF SHORT LEG CAST (BELOW KNEE TO TOES);
29425	APPLICATION OF SHORT LEG CAST (BELOW KNEE TO TOES); WALKING OR AMBULATORY TYPE

Valid E&M Codes for Qualified Encounters	Description
29515	APPLICATION OF SHORT LEG SPLINT (CALF TO FOOT)
29540	STRAPPING; ANKLE AND/OR FOOT
29550	STRAPPING; TOES
29580	STRAPPING; UNNA BOOT
29581	APPLICATION OF MULTI-LAYER COMPRESSION SYSTEM; LEG (BELOW KNEE), INCLUDING
29582	APPLICATION OF MULTI-LAYER COMPRESSION SYSTEM; THIGH AND LEG, INCLUDING ANKLE
29583	APPLICATION OF MULTI-LAYER COMPRESSION SYSTEM; UPPER ARM AND FOREARM
29584	APPLICATION OF MULTI-LAYER COMPRESSION SYSTEM; UPPER ARM, FOREARM, HAND, AND
30300	REMOVAL FOREIGN BODY, INTRANASAL; OFFICE TYPE PROCEDURE
30901	CONTROL NASAL HEMORRHAGE, ANTERIOR, SIMPLE (LIMITED CAUTERY AND/OR PACKING) ANY
31295	NASAL/SINUS ENDOSCOPY SURGICAL; WITH DILATION OF MAXILLARY SINUS OSTIUM (EG
31296	NASAL/SINUS ENDOSCOPY SURGICAL; WITH DILATION OF FRONTAL SINUS OSTIUM (EG
31297	NASAL/SINUS ENDOSCOPY SURGICAL; WITH DILATION OF SPHENOID SINUS OSTIUM (EG
31500	INTUBATION, ENDOTRACHEAL, EMERGENCY PROCEDURE
31515	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; FOR ASPIRATION
31520	LARYNGOSCOPY DIRECT, WITH OR WITHOUT TRACHEOSCOPY; DIAGNOSTIC, NEWBORN
31626	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN
31627	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN
31634	BRONCHOSCOPY RIGID OR FLEXIBLE INCLUDING FLUOROSCOPIC GUIDANCE WHEN
32551	TUBE THORACOSTOMY, INCLUDES CONNECTION TO DRAINAGE SYSTEM (EG, WATER SEAL),
32552	REMOVAL OF INDWELLING TUNNELED PLEURAL CATHETER WITH CUFF
32554	THORACENTESIS, NEEDLE OR CATHETER, ASPIRATION OF THE PLEURAL SPACE; WITHOUT
32555	THORACENTESIS, NEEDLE OR CATHETER, ASPIRATION OF THE PLEURAL SPACE; WITH
32556	PLEURAL DRAINAGE, PERCUTANEOUS, WITH INSERTION OF INDWELLING CATHETER; WITHOUT
32557	PLEURAL DRAINAGE, PERCUTANEOUS, WITH INSERTION OF INDWELLING CATHETER; WITH
36000	INTRODUCTION OF NEEDLE OR INTRACATHETER, VEIN
36430	TRANSFUSION, BLOOD OR BLOOD COMPONENTS

Valid E&M Codes for Qualified Encounters	Description
36600	ARTERIAL PUNCTURE, WITHDRAWAL OF BLOOD FOR DIAGNOSIS
36660	CATHETERIZATION, UMBILICAL ARTERY, NEWBORN, FOR DIAGNOSIS OR THERAPY
38300	DRAINAGE OF LYMPH NODE ABSCESS OR LYMPHADENITIS; SIMPLE
38505	BIOPSY OR EXCISION OF LYMPH NODE(S); BY NEEDLE, SUPERFICIAL (EG, CERVICAL,
39540	REPAIR, DIAPHRAGMATIC HERNIA (OTHER THAN NEONATAL), TRAUMATIC; ACUTE
45300	PROCTOSIGMOIDOSCOPY, RIGID; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF
45330	SIGMOIDOSCOPY, FLEXIBLE; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S)
46083	INCISION OF THROMBOSED HEMORRHOID, EXTERNAL
46600	ANOSCOPY; DIAGNOSTIC, WITH OR WITHOUT COLLECTION OF SPECIMEN(S) BY BRUSHING OR
46604	ANOSCOPY; WITH DILATION (EG, BALLOON, GUIDE WIRE, BOUGIE)
46608	ANOSCOPY; WITH REMOVAL OF FOREIGN BODY
46900	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM
46924	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM
49082	ABDOMINAL PARACENTESIS (DIAGNOSTIC OR THERAPEUTIC); WITHOUT IMAGING GUIDANCE
49083	ABDOMINAL PARACENTESIS (DIAGNOSTIC OR THERAPEUTIC); WITH IMAGING GUIDANCE
51100	ASPIRATION OF BLADDER; BY NEEDLE
51101	ASPIRATION OF BLADDER; BY TROCAR OR INTRACATHETER
52287	CYSTOURETHROSCOPY, WITH INJECTION(S) FOR CHEMODENERVATION OF THE BLADDER
54050	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM
54056	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM
54065	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM
55200	VASOTOMY, CANNULIZATION WITH OR WITHOUT INCISION OF VAS, UNILATERAL OR
55250	VASECTOMY, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE), INCLUDING
55300	VASOTOMY FOR VASOGRAMS, SEMINAL VESICULOGRAMS, OR EPIDIDYMOGRAMS, UNILATERAL OR
55450	LIGATION (PERCUTANEOUS) OF VAS DEFERENS, UNILATERAL OR BILATERAL (SEPARATE

Valid E&M Codes for Qualified Encounters	Description
55600	VESICULOTOMY;
56405	INCISION AND DRAINAGE OF VULVA OR PERINEAL ABSCESS
56420	INCISION AND DRAINAGE OF BARTHOLIN'S GLAND ABSCESS
56440	MARSUPIALIZATION OF BARTHOLIN'S GLAND CYST
56441	LYSIS OF LABIAL ADHESIONS
56442	HYMENOTOMY SIMPLE INCISION
56501	DESTRUCTION OF LESION(S), VULVA; SIMPLE (EG, LASER SURGERY, ELECTROSURGERY,
56515	DESTRUCTION OF LESION(S), VULVA; EXTENSIVE (EG, LASER SURGERY, ELECTROSURGERY,
56605	BIOPSY OF VULVA OR PERINEUM (SEPARATE PROCEDURE); ONE LESION
56740	EXCISION OF BARTHOLIN'S GLAND OR CYST
56820	COLPOSCOPY OF THE VULVA;
56821	COLPOSCOPY OF THE VULVA; WITH BIOPSY(S)
57061	DESTRUCTION OF VAGINAL LESION(S); SIMPLE (EG, LASER SURGERY, ELECTROSURGERY,
57065	DESTRUCTION OF VAGINAL LESION(S); EXTENSIVE (EG, LASER SURGERY, ELECTROSURGERY,
57100	BIOPSY OF VAGINAL MUCOSA; SIMPLE (SEPARATE PROCEDURE)
57105	BIOPSY OF VAGINAL MUCOSA; EXTENSIVE, REQUIRING SUTURE (INCLUDING CYSTS)
57135	EXCISION OF VAGINAL CYST OR TUMOR
57150	IRRIGATION OF VAGINA AND/OR APPLICATION OF MEDICAMENT FOR TREATMENT OF
57160	FITTING AND INSERTION OF PESSARY OR OTHER INTRAVAGINAL SUPPORT DEVICE
57170	DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS
57420	COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX IF PRESENT;
57421	COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX IF PRESENT; WITH BIOPSY(S) OF
57452	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA;
57454	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH BIOPSY(S) OF THE
57455	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH BIOPSY(S) OF THE
57456	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH ENDOCERVICAL
57460	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH LOOP ELECTRODE

Valid E&M Codes for Qualified Encounters	Description
57461	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH LOOP ELECTRODE
57500	BIOPSY, SINGLE OR MULTIPLE, OR LOCAL EXCISION OF LESION, WITH OR WITHOUT
57505	ENDOCERVICAL CURETTAGE (NOT DONE AS PART OF A DILATION AND CURETTAGE)
57510	CAUTERY OF CERVIX; ELECTRO OR THERMAL
57511	CAUTERY OF CERVIX; CRYOCAUTERY, INITIAL OR REPEAT
57513	CAUTERY OF CERVIX; LASER ABLATION
57520	CONIZATION OF CERVIX, WITH OR WITHOUT FULGURATION, WITH OR WITHOUT DILATION AND
57522	CONIZATION OF CERVIX, WITH OR WITHOUT FULGURATION, WITH OR WITHOUT DILATION AND
57558	DILATION AND CURETTAGE OF CERVICAL STUMP
57800	DILATION OF CERVICAL CANAL, INSTRUMENTAL (SEPARATE PROCEDURE)
58100	ENDOMETRIAL SAMPLING (BIOPSY) WITH OR WITHOUT ENDOCERVICAL SAMPLING (BIOPSY),
58110	ENDOMETRIAL SAMPLING (BIOPSY) PERFORMED IN CONJUNCTION WITH COLPOSCOPY (LIST
58120	DILATION AND CURETTAGE, DIAGNOSTIC AND/OR THERAPEUTIC (NONOBSTETRICAL)
58300	INSERTION OF INTRAUTERINE DEVICE (IUD)
58301	REMOVAL OF INTRAUTERINE DEVICE (IUD)
58340	CATHETERIZATION AND INTRODUCTION OF SALINE OR CONTRAST MATERIAL FOR SALINE
58558	HYSTEROSCOPY, SURGICAL; WITH SAMPLING (BIOPSY) OF ENDOMETRIUM AND/OR
58565	HYSTEROSCOPY, SURGICAL; WITH BILATERAL FALLOPIAN TUBE CANNULATION TO INDUCE
59025	FETAL NON-STRESS TEST
59051	FETAL MONITORING DURING LABOR BY CONSULTING PHYSICIAN (IE, NON-ATTENDING
59409	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS);
59425	ANTEPARTUM CARE ONLY; 4-6 VISITS
59426	ANTEPARTUM CARE ONLY; 7 OR MORE VISITS
59430	POSTPARTUM CARE ONLY (SEPARATE PROCEDURE)
59812	TREATMENT OF INCOMPLETE ABORTION, ANY TRIMESTER, COMPLETED SURGICALLY
60300	ASPIRATION AND/OR INJECTION THYROID CYST
62270	SPINAL PUNCTURE, LUMBAR, DIAGNOSTIC
62272	SPINAL PUNCTURE, THERAPEUTIC, FOR DRAINAGE OF CEREBROSPINAL FLUID (BY NEEDLE OR
62369	ELECTRONIC ANALYSIS OF PROGRAMMABLE, IMPLANTED PUMP FOR INTRATHECAL OR EPIDURAL

Valid E&M Codes for Qualified Encounters	Description
62370	ELECTRONIC ANALYSIS OF PROGRAMMABLE, IMPLANTED PUMP FOR INTRATHECAL OR EPIDURAL
64430	INJECTION, ANESTHETIC AGENT; PUDENDAL NERVE
64450	INJECTION, ANESTHETIC AGENT; OTHER PERIPHERAL NERVE OR BRANCH
64455	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, PLANTAR COMMON DIGITAL NERVE(S)
64611	CHEMODENERVATION OF PAROTID AND SUBMANDIBULAR SALIVARY GLANDS BILATERAL
64615	CHEMODENERVATION OF MUSCLE(S); MUSCLE(S) INNERVATED BY FACIAL, TRIGEMINAL,
64632	DESTRUCTION BY NEUROLYTIC AGENT; PLANTAR COMMON DIGITAL NERVE
64650	CHEMODENERVATION OF ECCRINE GLANDS; BOTH AXILLAE
64653	CHEMODENERVATION OF ECCRINE GLANDS; OTHER AREA(S) (EG, SCALP, FACE, NECK), PER
65205	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CONJUNCTIVAL SUPERFICIAL
65222	REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CORNEAL, WITH SLIT LAMP
65778	PLACEMENT OF AMNIOTIC MEMBRANE ON THE OCULAR SURFACE FOR WOUND HEALING;
65779	PLACEMENT OF AMNIOTIC MEMBRANE ON THE OCULAR SURFACE FOR WOUND HEALING; SINGLE
66821	DISCISSION OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE
67229	TREATMENT OF EXTENSIVE OR PROGRESSIVE RETINOPATHY ONE OR MORE SESSIONS;
67820	CORRECTION OF TRICHIASIS; EPILATION, BY FORCEPS ONLY
68761	CLOSURE OF THE LACRIMAL PUNCTUM; BY PLUG, EACH
68801	DILATION OF LACRIMAL PUNCTUM, WITH OR WITHOUT IRRIGATION
68816	PROBING OF NASOLACRIMAL DUCT WITH OR WITHOUT IRRIGATION; WITH TRANSLUMINAL
69000	DRAINAGE EXTERNAL EAR, ABSCESS OR HEMATOMA; SIMPLE
69200	REMOVAL FOREIGN BODY FROM EXTERNAL AUDITORY CANAL; WITHOUT GENERAL ANESTHESIA
69210	REMOVAL IMPACTED CERUMEN (SEPARATE PROCEDURE), ONE OR BOTH EARS
69424	VENTILATING TUBE REMOVAL REQUIRING GENERAL ANESTHESIA
70554	MAGNETIC RESONANCE IMAGING BRAIN FUNCTIONAL MRI; INCLUDING TEST SELECTION AND
72291	RADIOLOGICAL SUPERVISION AND INTERPRETATION, PERCUTANEOUS VERTEBROPLASTY,

Valid E&M Codes for Qualified Encounters	Description
74174	COMPUTED TOMOGRAPHIC ANGIOGRAPHY, ABDOMEN AND PELVIS, WITH CONTRAST
74176	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL
74177	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITH CONTRAST MATERIAL(S)
74178	COMPUTED TOMOGRAPHY, ABDOMEN AND PELVIS; WITHOUT CONTRAST MATERIAL IN ONE OR
76776	ULTRASOUND TRANSPLANTED KIDNEY REAL TIME AND DUPLEX DOPPLER WITH IMAGE
76801	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND
76802	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND
76805	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND
76810	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND
76811	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND
76815	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, LIMITED (EG,
76816	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FOLLOW-UP (EG,
76817	ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, TRANSVAGINAL
76819	FETAL BIOPHYSICAL PROFILE; WITHOUT NON-STRESS TESTING
76830	ULTRASOUND, TRANSVAGINAL
76831	SALINE INFUSION SONOHYSTEROGRAPHY (SIS), INCLUDING COLOR FLOW DOPPLER, WHEN
76856	ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE
76857	ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; LIMITED
76870	ULTRASOUND, SCROTUM AND CONTENTS
76872	ULTRASOUND, TRANSRECTAL;
76881	ULTRASOUND EXTREMITY NONVASCULAR REAL-TIME WITH IMAGE DOCUMENTATION; COMPLETE
76882	ULTRASOUND EXTREMITY NONVASCULAR REAL-TIME WITH IMAGE DOCUMENTATION;
77002	FLUOROSCOPIC GUIDANCE FOR NEEDLE PLACEMENT (EG BIOPSY ASPIRATION INJECTION
77003	FLUOROSCOPIC GUIDANCE AND LOCALIZATION OF NEEDLE OR CATHETER TIP FOR SPINE OR
77011	COMPUTED TOMOGRAPHY GUIDANCE FOR STEREOTACTIC LOCALIZATION

Valid E&M Codes for Qualified Encounters	Description
77012	COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT (EG BIOPSY ASPIRATION
77031	STEREOTACTIC LOCALIZATION GUIDANCE FOR BREAST BIOPSY OR NEEDLE PLACEMENT (EG
77032	MAMMOGRAPHIC GUIDANCE FOR NEEDLE PLACEMENT, BREAST (EG, FOR WIRE LOCALIZATION
77051	COMPUTER-AIDED DETECTION (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR
77052	COMPUTER-AIDED DETECTION (COMPUTER ALGORITHM ANALYSIS OF DIGITAL IMAGE DATA FOR
77053	MAMMARY DUCTOGRAM OR GALACTOGRAM SINGLE DUCT RADIOLOGICAL SUPERVISION AND
77054	MAMMARY DUCTOGRAM OR GALACTOGRAM MULTIPLE DUCTS RADIOLOGICAL SUPERVISION AND
77055	MAMMOGRAPHY; UNILATERAL
77056	MAMMOGRAPHY; BILATERAL
77057	SCREENING MAMMOGRAPHY, BILATERAL (2-VIEW FILM STUDY OF EACH BREAST)
77058	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S);
77059	MAGNETIC RESONANCE IMAGING, BREAST, WITHOUT AND/OR WITH CONTRAST MATERIAL(S);
77071	MANUAL APPLICATION OF STRESS PERFORMED BY PHYSICIAN OR OTHER QUALIFIED HEALTH
77072	BONE AGE STUDIES
77073	BONE LENGTH STUDIES (ORTHOROENTGENOGRAM, SCANOGRAM)
77074	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; LIMITED (EG, FOR METASTASES)
77075	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY; COMPLETE (AXIAL AND APPENDICULAR
77076	RADIOLOGIC EXAMINATION, OSSEOUS SURVEY, INFANT
77077	JOINT SURVEY, SINGLE VIEW, 2 OR MORE JOINTS (SPECIFY)
80195	SIROLIMUS
90681	IHS EPSDT: ONE IMMUNIZATION
90696	DIPHTHERIA, TETANUS TOXOIDS, ACELLULAR PERTUSSIS VACCINE AND POLIOVIRUS
90791	CHEMOTHERAPY INFUSION
90792	CHEMOTHERAPY PERFUSION
90832	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER
90833	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH
90834	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER

Valid E&M Codes for Qualified Encounters	Description
90836	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH
90837	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT AND/OR FAMILY MEMBER
90838	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT AND/OR FAMILY MEMBER WHEN PERFORMED WITH
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES
90840	INDIVIDUAL PSYCHOTHERAPY HALF HOUR
90846	FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT)
90847	FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT)
90849	MULTIPLE-FAMILY GROUP PSYCHOTHERAPY
90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)
90951	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS YOUNGER
90952	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS YOUNGER
90953	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS YOUNGER
90954	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 2-11
90955	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 2-11
90956	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 2-11
90957	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 12-19
90958	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 12-19
90959	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 12-19
90960	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 20 YEARS
90961	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 20 YEARS
90962	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 20 YEARS
90963	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR HOME DIALYSIS PER FULL
90964	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR HOME DIALYSIS PER FULL
90965	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR HOME DIALYSIS PER FULL
90966	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR HOME DIALYSIS PER FULL

Valid E&M Codes for Qualified Encounters	Description
90967	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR DIALYSIS LESS THAN A FULL
90968	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR DIALYSIS LESS THAN A FULL
90969	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR DIALYSIS LESS THAN A FULL
90970	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR DIALYSIS LESS THAN A FULL
92002	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND EVALUATION WITH INITIATION
92004	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND EVALUATION WITH INITIATION
92012	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND EVALUATION, WITH INITIATION
92014	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND EVALUATION, WITH INITIATION
92020	GONIOSCOPY (SEPARATE PROCEDURE)
92025	COMPUTERIZED CORNEAL TOPOGRAPHY UNILATERAL OR BILATERAL WITH INTERPRETATION
92071	FITTING OF CONTACT LENS FOR TREATMENT OF OCULAR SURFACE DISEASE
92072	FITTING OF CONTACT LENS FOR MANAGEMENT OF KERATOCONUS, INITIAL FITTING
92081	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND
92082	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND
92083	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND
92100	SERIAL TONOMETRY (SEPARATE PROCEDURE) WITH MULTIPLE MEASUREMENTS OF INTRAOCULAR
92132	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING ANTERIOR SEGMENT WITH
92133	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING POSTERIOR SEGMENT WITH
92134	SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING POSTERIOR SEGMENT WITH
92227	REMOTE IMAGING FOR DETECTION OF RETINAL DISEASE (EG RETINOPATHY IN A PATIENT
92228	REMOTE IMAGING FOR MONITORING AND MANAGEMENT OF ACTIVE RETINAL DISEASE (EG
92250	FUNDUS PHOTOGRAPHY WITH INTERPRETATION AND REPORT
92285	EXTERNAL OCULAR PHOTOGRAPHY WITH INTERPRETATION AND REPORT FOR DOCUMENTATION OF
92540	BASIC VESTIBULAR EVALUATION, INCLUDES SPONTANEOUS NYSTAGMUS TEST WITH ECCENTRIC

Valid E&M Codes for Qualified Encounters	Description
92550	TYMPANOMETRY AND REFLEX THRESHOLD MEASUREMENTS
92551	SCREENING TEST, PURE TONE, AIR ONLY
92552	PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY
92567	TYMPANOMETRY (IMPEDANCE TESTING)
92568	ACOUSTIC REFLEX TESTING; THRESHOLD
92570	ACOUSTIC IMMITTANCE TESTING, INCLUDES TYMPANOMETRY (IMPEDANCE TESTING),
92618	EVALUATION FOR PRESCRIPTION OF NON-SPEECH-GENERATING AUGMENTATIVE AND
92626	EVALUATION OF AUDITORY REHABILITATION STATUS; FIRST HOUR
92627	EVALUATION OF AUDITORY REHABILITATION STATUS; EACH ADDITIONAL 15 MINUTES (LIST
92630	AUDITORY REHABILITATION; PRE-LINGUAL HEARING LOSS
92633	AUDITORY REHABILITATION; POST-LINGUAL HEARING LOSS
93279	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE
93280	CARDIAC FLUOROSCOPY
93281	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE
93282	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE
93283	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE
93284	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE
93285	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE
93286	PERI-PROCEDURAL DEVICE EVALUATION (IN PERSON) AND PROGRAMMING OF DEVICE SYSTEM
93287	PERI-PROCEDURAL DEVICE EVALUATION (IN PERSON) AND PROGRAMMING OF DEVICE SYSTEM
93288	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT BY
93289	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT BY
93290	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT BY
93291	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT BY
93292	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH ANALYSIS, REVIEW AND REPORT BY
93293	TRANSTELEPHONIC RHYTHM STRIP PACEMAKER EVALUATION(S) SINGLE, DUAL, OR MULTIPLE

Valid E&M Codes for Qualified Encounters	Description
93294	INTERROGATION DEVICE EVALUATION(S) (REMOTE), UP TO 90 DAYS; SINGLE, DUAL, OR
93295	INTERROGATION DEVICE EVALUATION(S) (REMOTE), UP TO 90 DAYS; SINGLE, DUAL, OR
93296	INTERROGATION DEVICE EVALUATION(S) (REMOTE), UP TO 90 DAYS; SINGLE, DUAL, OR
93297	INTERROGATION DEVICE EVALUATION(S), (REMOTE) UP TO 30 DAYS; IMPLANTABLE
93298	INTERROGATION DEVICE EVALUATION(S), (REMOTE) UP TO 30 DAYS; IMPLANTABLE LOOP
93750	INTERROGATION OF VENTRICULAR ASSIST DEVICE (VAD), IN PERSON, WITH PHYSICIAN OR
93922	LIMITED BILATERAL NONINVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY
93925	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; COMPLETE
93970	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER
93971	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER
93975	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL
94010	SPIROMETRY, INCLUDING GRAPHIC RECORD, TOTAL AND TIMED VITAL CAPACITY,
94011	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS IN AN INFANT OR CHILD
94012	MEASUREMENT OF SPIROMETRIC FORCED EXPIRATORY FLOWS, BEFORE AND AFTER
94013	MEASUREMENT OF LUNG VOLUMES (IE, FUNCTIONAL RESIDUAL CAPACITY FRCÙ, FORCED
94060	BRONCHODILATION RESPONSIVENESS, SPIROMETRY AS IN 94010, PRE- AND
94640	PRESSURIZED OR NONPRESSURIZED INHALATION TREATMENT FOR ACUTE AIRWAY OBSTRUCTION
94664	DEMONSTRATION AND/OR EVALUATION OF PATIENT UTILIZATION OF AN AEROSOL GENERATOR,
94726	PLETHYSMOGRAPHY FOR DETERMINATION OF LUNG VOLUMES AND, WHEN PERFORMED, AIRWAY
94727	GAS DILUTION OR WASHOUT FOR DETERMINATION OF LUNG VOLUMES AND, WHEN PERFORMED,
94728	AIRWAY RESISTANCE BY IMPULSE OSCILLOMETRY
94729	DIFFUSING CAPACITY (EG, CARBON MONOXIDE, MEMBRANE) (LIST SEPARATELY IN ADDITION
94780	CAR SEAT/BED TESTING FOR AIRWAY INTEGRITY, NEONATE, WITH CONTINUAL NURSING
94781	CAR SEAT/BED TESTING FOR AIRWAY INTEGRITY, NEONATE, WITH CONTINUAL NURSING
94799	UNLISTED PULMONARY SERVICE OR PROCEDURE

Valid E&M Codes for Qualified Encounters	Description
95004	PERCUTANEOUS TESTS (SCRATCH, PUNCTURE, PRICK) WITH ALLERGENIC EXTRACTS,
95017	ALLERGY TESTING, ANY COMBINATION OF PERCUTANEOUS (SCRATCH, PUNCTURE, PRICK) AND
95018	ALLERGY TESTING, ANY COMBINATION OF PERCUTANEOUS (SCRATCH, PUNCTURE, PRICK) AND
95076	INGESTION CHALLENGE TEST (SEQUENTIAL AND INCREMENTAL INGESTION OF TEST ITEMS,
95115	PROFESSIONAL SERVICES FOR ALLERGEN IMMUNOTHERAPY NOT INCLUDING PROVISION OF
95117	PROFESSIONAL SERVICES FOR ALLERGEN IMMUNOTHERAPY NOT INCLUDING PROVISION OF
95831	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE) WITH REPORT; EXTREMITY (EXCLUDING
95832	MUSCLE TESTING, MANUAL (SEPARATE PROCEDURE) WITH REPORT; HAND, WITH OR WITHOUT
95885	NEEDLE ELECTROMYOGRAPHY, EACH EXTREMITY, WITH RELATED PARASPINAL AREAS, WHEN
95886	NEEDLE ELECTROMYOGRAPHY, EACH EXTREMITY, WITH RELATED PARASPINAL AREAS, WHEN
95887	NEEDLE ELECTROMYOGRAPHY, NON-EXTREMITY (CRANIAL NERVE SUPPLIED OR AXIAL)
95905	MOTOR AND/OR SENSORY NERVE CONDUCTION, USING PRECONFIGURED ELECTRODE ARRAY(S),
95938	SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY, STIMULATION OF ANY/ALL
95939	CENTRAL MOTOR EVOKED POTENTIAL STUDY (TRANSCRANIAL MOTOR STIMULATION); IN UPPER
96101	PSYCHOLOGICAL TESTING (INCLUDES PSYCHODIAGNOSTIC ASSESSMENT OF EMOTIONALITY,
96110	DEVELOPMENTAL SCREEN W/SCORE
96116	NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING, REASONING AND
96118	NEUROPSYCHOLOGICAL TESTING (EG, HALSTEAD-REITAN NEUROPSYCHOLOGICAL BATTERY,
96150	HEALTH AND BEHAVIOR ASSESSMENT (EG, HEALTH-FOCUSED CLINICAL INTERVIEW,
96151	HEALTH AND BEHAVIOR ASSESSMENT (EG, HEALTH-FOCUSED CLINICAL INTERVIEW,
96152	HEALTH AND BEHAVIOR INTERVENTION, EACH 15 MINUTES, FACE-TO-FACE; INDIVIDUAL
96154	HEALTH AND BEHAVIOR INTERVENTION, EACH 15 MINUTES, FACE-TO-FACE; FAMILY (WITH
96360	INTRAVENOUS INFUSION, HYDRATION; INITIAL, 31 MINUTES TO 1 HOUR
96361	INTRAVENOUS INFUSION, HYDRATION; EACH ADDITIONAL HOUR (LIST SEPARATELY IN

Valid E&M Codes for Qualified Encounters	Description
96365	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE
96366	INTRAVENUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNSIS (SPECIFY SUBSTANCE
96367	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE
96368	INTRAVENUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNSIS (SPECIFY SUBSTANCE
96369	SUBCUTANEOUS INFUSION FOR THERAPY OR PROPHYLAXIS (SPECIFY SUBSTANCE OR DRUG);
96370	SUBCUTANEOUS INFUSION FOR THERAPY OR PROPHYLAXIS (SPECIFY SUBSTANCE OR DRUG);
96371	SUBCUTANEOUS INFUSION FOR THERAPY OR PROPHYLAXIS (SPECIFY SUBSTANCE OR DRUG);
96372	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG);
96373	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG);
96374	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG);
96375	THERAPEUTIC, PROPHYLACTIC, OR DIAGNSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG);
96376	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG);
96401	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR INTRAMUSCULAR; NON-HORMONAL
96402	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR INTRAMUSCULAR; HORMONAL
96409	CHEMOTHERAPY ADMINISTRATION; INTRAVENOUS, PUSH TECHNIQUE, SINGLE OR INITIAL
96411	CHEMOTHERAPY ADMINISTRATION; INTRAVENOUS, PUSH TECHNIQUE, EACH ADDITIONAL
96413	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; UP TO 1 HOUR,
96415	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; EACH ADDITIONAL
96416	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; INITIATION OF
96417	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; EACH ADDITIONAL
96446	CHEMOTHERAPY ADMINISTRATION INTO THE PERITONEAL CAVITY VIA INDWELLING PORT OR
97010	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HOT OR COLD PACKS
97012	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; TRACTION, MECHANICAL
97014	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL STIMULATION

Valid E&M Codes for Qualified Encounters	Description
97016	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; VASOPNEUMATIC DEVICES
97018	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; PARAFFIN BATH
97022	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; WHIRLPOOL
97024	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; DIATHERMY (EG, MICROWAVE)
97026	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; INFRARED
97028	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRAVIOLET
97032	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ELECTRICAL STIMULATION
97033	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; IONTOPHORESIS, EACH 15 MINUTES
97034	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; CONTRAST BATHS, EACH 15 MINUTES
97035	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES
97036	APPLICATION OF A MODALITY TO ONE OR MORE AREAS; HUBBARD TANK, EACH 15 MINUTES
97110	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC
97112	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR
97113	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERAPY WITH
97116	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING
97124	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING
97140	MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL LYMPHATIC
97597	DEBRIDEMENT (EG, HIGH PRESSURE WATERJET WITH/WITHOUT SUCTION, SHARP SELECTIVE
97598	DEBRIDEMENT (EG, HIGH PRESSURE WATERJET WITH/WITHOUT SUCTION, SHARP SELECTIVE
97602	REMOVAL OF DEVITALIZED TISSUE FROM WOUND(S), NON-SELECTIVE DEBRIDEMENT, WITHOUT
98925	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 1-2 BODY REGIONS INVOLVED
98926	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 3-4 BODY REGIONS INVOLVED
98927	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 5-6 BODY REGIONS INVOLVED
98928	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 7-8 BODY REGIONS INVOLVED

Valid E&M Codes for Qualified Encounters	Description
98929	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 9-10 BODY REGIONS INVOLVED
98940	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 1-2 REGIONS
98941	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 3-4 REGIONS
98942	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 5 REGIONS
99201	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW
99202	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW
99203	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW
99204	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW
99205	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW
99211	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN
99212	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN
99213	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN
99214	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN
99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN
99224	SUBSEQUENT OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A
99225	SUBSEQUENT OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A
99226	SUBSEQUENT OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A
99241	OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE 3
99242	OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE 3
99243	OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE 3
99244	OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE 3
99245	OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE 3
99304	INITIAL NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A
99305	INITIAL NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A

Valid E&M Codes for Qualified Encounters	Description
99306	INITIAL NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A
99307	SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF
99308	SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF
99309	SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF
99310	SUBSEQUENT NURSING FACILITY CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF
99315	NURSING FACILITY DISCHARGE DAY MANAGEMENT; 30 MINUTES OR LESS
99318	EVALUATION AND MANAGEMENT OF A PATIENT INVOLVING AN ANNUAL NURSING FACILITY
99324	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW
99325	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW
99326	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW
99327	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW
99328	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW
99334	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN
99335	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN
99336	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN
99337	DOMICILIARY OR REST HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN
99341	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES
99342	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES
99343	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES
99347	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH
99348	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH
99349	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH
99350	HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH
99354	PROLONGED SERVICE IN THE OFFICE OR OTHER OUTPATIENT SETTING REQUIRING DIRECT

Valid E&M Codes for Qualified Encounters	Description
99355	PROLONGED SERVICE IN THE OFFICE OR OTHER OUTPATIENT SETTING REQUIRING DIRECT
99356	PROLONGED SERVICE IN THE INPATIENT OR OBSERVATION SETTING, REQUIRING UNIT/FLOOR
99357	PROLONGED SERVICE IN THE INPATIENT OR OBSERVATION SETTING, REQUIRING UNIT/FLOOR
99381	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN
99382	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN
99383	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN
99384	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN
99385	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN
99386	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN
99387	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN
99391	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN
99392	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN
99393	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN
99394	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN
99395	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN
99396	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN
99397	PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN
99401	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S)
Q0091	OBTAINING SCREEN PAP SMEAR
D0120	Periodic oral examination
D0140	Limited oral examination-problem focused
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150	Comprehensive oral examination-new or established patient
D0160	Detailed and extensive oral evaluation-problem focused by report
D0170	Re-evaluation-limited, problem focused (established patient; not post-operative visit)

Valid E&M Codes for Qualified Encounters	Description
D0210	Intraoral - complete series (including bitewings)
D0220	Intraoral-periapical-first film
D0230	Intraoral-periapical-each additional film
D0240	Intraoral-occlusal film
D0250	Extraoral-first film
D0260	Extraoral - each additional film
D0270	Bitewing-single film
D0272	Bitewings-two films
D0273	Bitewings - three films
D0274	Bitewings - four films
D0277	Vertical bitewings - 7 to 8 films
D0290	Posteroanterior and lateral skull and facial bone, survey film
D0310	Sialography
D0330	Panoramic film
D0340	Cephalometric film
D1110	Prophylaxis-adult
D1120	Prophylaxis-child
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients
D1208	Topical application of fluoride
D1351	Sealant-per tooth
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth
D1510	Space maintainer-fixed-unilateral
D1515	Space maintainer-fixed-bilateral
D1520	Space maintainer-removable-unilateral
D1525	Space maintainer-removable-bilateral
D1550	Recementation of space maintainer
D1555	Removal of fixed space maintainer
D2140	Amalgam-one surface, primary or permanent
D2150	Amalgam-two surfaces, primary or permanent
D2160	Amalgam-three surfaces, primary or permanent
D2161	Amalgam-four or more surface-primary or permanent
D2330	Resin-based composite-one surface, anterior
D2331	Resin-based composite-two surfaces, anterior
D2332	Resin-based composite-three surfaces, anterior
D2335	Resin-based composite-four or more surfaces or involving incisal angle (anterior)
D2390	Resin-based composite crown, anterior (replacement code for D2336)
D2391	Resin-based composite - one surface, posterior-permanent (replaces D2380 and D2385)

Valid E&M Codes for Qualified Encounters	Description
D2392	Resin-based composite-two surfaces, posterior-permanent
D2393	Resin-based composite-three surfaces, posterior-permanent
D2394	Resin-based composite-four or more surfaces, posterior, permanent
D2910	Recement inlay
D2920	Recement crown
D2930	Prefabricated stainless steel crown-primary tooth
D2931	Prefabricated stainless steel crown-permanent tooth
D2932	Prefabricated resin crown
D2933	Prefabricated stainless steel crown with resin window
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth
D2940	Sedative filling
D2980	Crown repair-by report
D2990	Resin infiltration of incipient smooth surface lesions
D3220	Therapeutic pulpotomy (excluding final restoration)-removal of pulp coronal to the dentinocemental junction and application of medicament
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development
D3230	Pulpal therapy (resorbable filling)-anterior, primary tooth (excluding final restoration)
D3240	Pulpal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration)
D3310	Anterior (excluding final restoration)
D3320	Bicuspid (excluding final restoration)
D3330	Molar (excluding final restoration)
D3346	Retreatment of previous root canal therapy-anterior
D3347	Retreatment of previous root canal therapy-bicuspid
D3348	Retreatment of previous root canal therapy-molar
D3351	Apexification/relcalcification-initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352	Apexification/relcalcification-interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353	Apexification/relcalcification-final visit (includes completed root canal therapy-apical closure/calcific repair of perforations, root resorption, etc.)
D3354	Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration

Valid E&M Codes for Qualified Encounters	Description
D3410	Apicoectomy/periradicular surgery-anterior
D3421	Apicoectomy/periradicular surgery- bicuspid (first root)
D3425	Apicoectomy/periradicular surgery-molar (first root)
D3426	Apicoectomy/periradicular surgery-(each additional root)
D3430	Retrograde filling-per root
D4210	Gingivectomy or ginivoplasty-four or more contiguous teeth or bounded teeth spaces, per quadrant
D4211	Gingivectomy or ginivoplasty-one to three teeth per quadrant
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240	Gingival flap procedure, including root planning- four or more contiguous teeth or bounded teeth spaces, per quadrant
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant
D4341	Periodontal splinting-intracoronal
D4342	Periodontal scaling and root planning - one to three teeth, per quadrant
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis
D5110	Complete upper denture
D5120	Complete lower denture
D5130	Immediate upper
D5140	Immediate lower
D5211	Upper partial-acrylic base (including any conventional clasps and rests)
D5212	Lower partial-acrylic base (including any conventional clasps and rests)
D5213	Maxillary partial denture-cast metal framework with resin denture bases
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5221	Immed max part denture resin
D5222	Immed man part denture resin
D5223	Immed max part dent metal
D5224	Immed man part dent metal
D5510	Repair broken complete denture base
D5520	Replace missing or broken teeth- complete denture (each tooth)
D5610	Repair resin denture base
D5620	Repair cast framework
D5630	Repair or replace broken clasp

Valid E&M Codes for Qualified Encounters	Description
D5640	Replace broken teeth-per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture
D5730	Reline complete maxillary denture (chairside)
D5731	Reline complete mandibular denture (chairside)
D5740	Reline maxillary partial denture (chairside)
D5741	Reline mandibular partial denture (chairside)
D5750	Reline complete maxillary denture (laboratory)
D5751	Reline complete mandibular denture (laboratory)
D5760	Reline maxillary partial denture (laboratory)
D5761	Reline mandibular partial denture (laboratory)
D5820	Interim partial denture (maxillary)
D5821	Interim partial denture (mandibular)
D5899	OTHER DENTAL
D5951	Feeding aid
D5952	Speech aid prosthesis, pediatric
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
D6930	Recement fixed partial denture
D7111	Coronal remnants - deciduous tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth-soft tissue
D7230	Removal of impacted tooth-partially bony
D7240	Removal of impacted tooth-completely bony
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7251	Coronectomy - Intentional Partial Tooth Removal
D7260	Orolantral fistula closure
D7270	Tooth replacement and/or stabilization of accidentally evulsed or displaced tooth
D7280	Surgical access of an unerupted tooth
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption
D7285	Biopsy of oral tissue- hard (bone, tooth)
D7286	Biopsy or oral tissue- soft (all others)
D7310	Alveoplasty in conjunction with extractions-per quadrant

Valid E&M Codes for Qualified Encounters	Description
D7320	Alveoplasty not in conjunction with extractions-per quadrant
D7410	Excision Of Benign Lesion Up To 1.25 Cm
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm
D7441	Excision of malignant tumor- lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor-lesion diameter greater than 1.25 cm
D7471	Removal of lateral exostosis (maxilla or mandible)
D7510	Incision and drainage of abscess- intraoral soft tissue
D7520	Incision and drainage of abscess- extraoral soft tissue
D7610	Maxilla- open reduction (teeth immobilized, if present)
D7620	Maxilla- closed reduction (teeth immobilized, if present)
D7630	Mandible- open reduction (teeth immobilized, if present)
D7640	Mandible- closed reduction (teeth immobilized, if present)
D7660	Malar and/or zygomatic arch-closed reduction
D7670	Alveolus- closed reduction, may include stabilization of teeth
D7680	Facial bones- complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla- open reduction
D7720	Maxilla-Closed Reduction
D7730	Mandible- open reduction
D7740	Mandible- closed reduction
D7750	Malar and/or zygomatic arch-open reduction
D7770	Alveolus- open reduction stabilization of teeth
D7820	Closed reduction of dislocation
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture- up to 5 cm
D7912	Complicated suture- greater than 5 cm
D7980	Sialolithotomy
D7999	Unspecified oral surgery procedure, by report
D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition
D8030	Limited orthodontic treatment of the adolescent dentition
D8040	Limited orthodontic treatment of the adult dentition

Valid E&M Codes for Qualified Encounters	Description
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D9120	Fixed partial denture sectioning
D9220	Deep sedation/general anesthesia - first 30 minutes
D9221	Deep sedation/general anesthesia- each additional 15 minutes
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9241	Intravenous conscious sedation/analgesia-first 30 minutes
G0101	CA SCREEN; PELVIC/BREAST EXAM
G0438	ANNUAL WELLNESS VISIT - FIRST
G0439	ANNUAL WELLNESS VISIT - SUBSEQUENT