Errata and Technical Corrections – CPT® 2020
Date: August 3, 2020

The information that follows is sourced to either a publication errata or a technical correction by the CPT Editorial Panel. An errata (denoted as **E**) for the current edition of the CPT code set will publish information that was approved by the CPT Editorial Panel and inadvertently excluded from the current code set. Technical corrections (denoted as **T**) are clarifications of original Panel intent for the current code structure. All items below are errata if they are not designated as a technical correction in the right-hand column. The order of the entries on this document is by code order. Additionally, each entry shows the date of publication to this document. The links immediately following are provided as a guide to the most recently added items. **The effective date for each item is January 1, 2020**. Updates to this document are made as issues surface requiring clarification.

Most recent entries added to *Errata and Technical Corrections - CPT® 2020*

- **Revise the medium descriptor for code 37619.**

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Introduction
Instructions for Use of the CPT Codebook
Code Symbols

Posted
11/1/19
E

Duplicate proprietary laboratory analyses (PLA) tests are annotated by the ♓ symbol. PLA codes describe proprietary clinical laboratory analyses and can be either provided by a single ("sole-source") laboratory or licensed or marketed to multiple providing laboratories (eg, cleared or approved by the Food and Drug Administration [FDA]). All codes that are included in the PLA section are also included in Appendix O, with the procedure's proprietary name. In some instances, the descriptor language of PLA codes may be identical and the code may only be differentiated by the listed proprietary name in Appendix O. When more than one PLA test has an identical descriptor, the codes will be denoted by the symbol ~~⇅~~ ♓.

Revise the duplicate PLA symbol to "♓" in the Code Symbols section of the Introduction of the CPT codebook.

Category I
Evaluation and Management
Non-Face-to-Face Services
Remote Physiologic Monitoring Treatment Management Services

Posted
03/02/2020
T

►Remote physiologic monitoring treatment management services are provided when clinical staff/physician/other qualified health care professional use the results of remote physiological monitoring to manage a patient under a specific treatment plan. To report remote physiological monitoring, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. Do not use 99457, 99458 for time that can be reported using more specific monitoring services (eg, for the patient that requires reevaluation of medication regimen and/or changes in treatment). Codes 99457, 99458 may be reported during the same service period as chronic care management services (99487, 99489, 99490), transitional care management services (99495, 99496), and behavioral health integration services (99484, 99492, 99493, 99494); however, time spent performing these services should remain separate and no time should be counted toward the required time for both services in a single month. Codes 99457, 99458 require a live, interactive communication with the patient/caregiver. For the first completed 20 minutes of clinical staff/physician/other qualified health care professional time in a calendar month report 99457, and report 99458 for each additional completed 20 minutes. Do not report 99457, 99458 for services of less than 20 minutes. Report 99457 one time regardless of the number of physiologic monitoring modalities performed in a given calendar month.

Do not count any time…◄

#▲99457 Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

(Report 99457 once for each 30 days, regardless of the number of parameters monitored)

►(Do not report 99457 for services of less than 20 minutes)◄

►(Do not report 99457 in conjunction with 93264, 99091)◄

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▶(Do not report 99457 in the same month as 99473, 99474)◀ #✚●99458 each additional 20 minutes (List separately in addition to code for primary procedure) ▶(Use 99458 in conjunction with 99457)◀ ~~▶(Report only 99457 if you have not completed 20 minutes of additional treatment regardless of time spent)◀~~ ▶(Do not report 99458 for services of less than an additional increment of 20 minutes)◀ **Revise the Remote Physiologic Monitoring and Treatment Management Services introductory guidelines to specify codes 99457, 99458 should be reported for the first completed 20 minutes and each additional completed 20 minutes, respectively, of clinical staff/physician/other qualified health care professional time in a calendar month.** **Delete the second instructional parenthetical note and revise the third instructional parenthetical note to specify "an additional increment of" 20 minutes following code 99458.**	
Category I **Surgery** **Integumentary System** **Skin, Subcutaneous, and Accessory Structures** **Pairing or Cutting** ▶(To report destruction of benign lesions other than skin tags or cutaneous vascular proliferative lesions, see ~~17000-17004~~ 17110, 17111)◀ 11055 Pairing or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion 11056 2 to 4 lesions 11057 more than 4 lesions **Revise the parenthetical note preceding code 11055 to specify the destruction of benign lesions other than skin tags or cutaneous vascular proliferative lesions should be reported with codes 17110, 17111.**	**Posted** **03/02/2020** **T**
Category I **Surgery** **Cardiovascular System** **Heart and Pericardium** **Electrophysiologic Operative Procedures** **Incision** ✚33257 Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	**Posted** **11/19/19** **E**

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(Use 33257 in conjunction with 33120-33130, 33250, 33251, 33261, 33300-33335, 33365, 33390, 33391, 33404-33417, 33420-33476, 33478, 33496, 33500-33507, 33510-33516, 33533-33548, 33600-33619, 33641-33697, 33702-33732, 33735-33767, 33770,-33877, 33910-33922, 33925, 33926, 33975, 33976, 33977, 33978, 33979, 33980, 33981, 33982, 33983) **Remove the comma and add a hyphen following code 33770 in the inclusionary parenthetical note following code 33257 to indicate that it is a range of codes between 33770 and 33877 (ie, 33770-33877).**	
Category I **Surgery** **Cardiovascular System** **Arteries and Veins** **Fenestrated Endovascular Repair of the Visceral and Infrarenal Aorta** ✚34709 Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure) (Use 34709 in conjunction with 34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34845, 34846, 34847, 34848) (34709 may only be reported once per vessel treated [ie, multiple endograft extensions placed in a single vessel may only be reported once]) (Do not report 34709 for placement of a docking limb that extends into the external iliac artery) (For placement of an iliac branched endograft, see 34717, 34718) (For endograft placement into a renal artery that is being covered by a proximal extension, see 37236, 37237) **Revise the first inclusionary parenthetical note following code 34709 to include codes 34845, 34846, 34847, and 34848.**	**Posted** **11/1/19** **T**
Category I **Surgery** **Nervous System** **Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System** **Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic** **Somatic Nerves**	**Posted** **11/1/19** **E**

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▶Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System			
Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic ~~Nerve~~			
Code(s)	Unit	Image Guidance Included	Image Guidance Separately Reported, When Performed
Somatic Nerve			
64400-64450	1 unit per plexus, nerve, or branch injected regardless of the number of injections		X

Revise the Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System chart to remove the term "Nerve" following "Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic."

Category I
Surgery
Nervous System
Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System
Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency), Chemodenervation
Somatic Nerves

Posted 07/01/2020 T

#64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

(For bilateral procedure, report 64633 with modifier 50)

#✚64636 lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)

(Use 64636 in conjunction with 64635)

(For bilateral procedure, report 64636 twice. Do not report modifier 50 in conjunction with 64636)

(Do not report 64633-64636 in conjunction with 77003, 77012)

(For radiofrequency ablation of nerves innervating the sacroiliac joint with image guidance, ~~destruction by neurolytic agent, individual nerves, sacroiliac joint,~~ use 64625 ~~64640~~)

Revise the fourth parenthetical note following code 64636 to clarify radiofrequency ablation of nerves innervating the sacroiliac joint with image guidance may be reported with code 64625.

Category I
Radiology
Radiologic Guidance
Fluoroscopic Guidance

Posted 11/19/19 E

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+77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure) (See appropriate surgical code for procedure and anatomic location) (Use 77002 in conjunction with 10160, 20206, 20220, 20225, 20520, 20525, 20526, 20550, 20551, 20552, 20553, 20555, 20600, 20605, 20610, 20612, 20615, 21116, 21550, 23350, 24220, 25246, 27093, 27095, 27369, 27648, 32400, 32405, 32553, 36002, 38220, 38221, 38222, 38505, 38794, 41019, 42400, 42405, 47000, 47001, 48102, 49180, 49411, 50200, 50390, 51100, 51101, 51102, 55700, 55876, 60100, 62268, 62269, 64400-64448, 64450, 64455, 64505, 64600, 64605) (77002 is included in all arthrography radiological supervision and interpretation codes. See **Administration of Contrast Material[s]** introductory guidelines for reporting of arthrography procedures) **+**77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure) (Use 77003 in conjunction with 61050, 61055, 62267, 62273, 62280, 62281, 62282, 62284, 64449, 64510, 64517, 64520, 64610, 96450) (Do not report 77003 in conjunction with 62270, 62272, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 62328, 62329) **Revise the inclusionary parenthetical notes following code 77002 to include 64400-64448, 64450, 64455, and code 77003 to include 64449.**	
Category I **Pathology and Laboratory** **Molecular Pathology** **Tier 1 Molecular Pathology Procedures** #81162 *BRCA1 (BRCA1, DNA repair associated)*, *BRCA2 (BRCA2, DNA repair associated)* (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (ie, detection of large gene rearrangements) (Do not report 81162 in conjunction with 81163, 81164, 81165, 81166, 81167, 81215, 81216, 81217, 81432) #81163 full sequence analysis #81164 full duplication/deletion analysis (ie, detection of large gene rearrangements) (To report *BRCA1, BRCA2* full sequence analysis and full duplication/deletion analysis on the same date of service, use 81162) (For analysis of common duplication/deletion variant(s) in *BRCA1* [ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb], use 81479) (Do not report 81163 in conjunction with 81162, 81164, 81165, 81216, 81432)	**Posted 11/1/19 E**

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(Do not report 81164 in conjunction with 81162, 81163, 81166, 81167, 81217)

81212 185delAG, 5385insC, 6174delT variants

(81211, 81213 have been deleted. To report see 81162, 81163, 81164)

(81214 has been deleted. To report, see 81165, 81166)

Revise the exclusionary parenthetical note following code 81162 to include code 81215.

Category I
Pathology and Laboratory
Genomic Sequencing Procedures and Other Molecular Multianalyte Assays

Posted 11/1/19 T

#81443 Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C, mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (eg, *ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH)*

(If spinal muscular atrophy testing is performed separately, use ~~81401~~ 81329)

(If testing is performed only for Ashkenazi Jewish-associated disorders, use 81412)

(If *FMR1* [expanded allele] testing is performed separately, use 81243)

(If hemoglobin A testing is performed separately, use 81257)

(Do not report 81443 in conjunction with 81412)

Revise the first instructional parenthetical note following code 81443 to remove code 81401 and add code 81329 for reporting spinal muscular atrophy testing when it is performed separately.

Category I
Medicine
Cardiovascular
Intracardiac Electrophysiological Procedures/Studies

Posted 03/02/2020 T

✚93662 Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)

(Use 93662 in conjunction with 92987, 93453, 93460-93462, 93532, 93580, 93581, 93582, 93583, 93620, 93621, 93622, 93653, 93654, 93656 as appropriate)

Revise the inclusionary parenthetical note following code 93662 to add codes 93582, 93583.

Category I
Medicine
Neurology and Neuromuscular Procedures
Special EEG Tests

Posted 01/31/2020 E

Technical Component Services

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Code 95700 describes any long-term continuous EEG/VEEG recording~~,~~ setup, takedown when performed, and patient/caregiver education by the EEG technologist(s). To report 95700, the setup must include a minimum of eight channels of EEG. Services with fewer than eight channels may be reported using 95999. Eight to 15 channels are typically used for neonates and when electrodes cannot be placed on certain regions of the scalp that are sterile. Twenty or more channels are typically used for children and adults. If setup is performed by someone who does not meet the definition of an EEG technologist(s), report 95999.

Revise the long-term EEG technical component services guidelines by deleting the comma between “recording” and “setup” to clarify that code 95700 includes recording setup (i.e., setup of the recording, not recording *and* setup).

Posted 11/22/19 E

▶Long-Term EEG Monitoring Table

Duration of Long-Term EEG/VEEG Recording	Professional Services		Technical Services		
	With report each 24 hours	With report at conclusion of entire recording period	Unmonitored	Intermittent	Continuous
36 hours and 1 minute to 50 hours (w/video)	95720 x 2	95722 x 1	95714 x 2	95715 x 2	95716 x 2
50 hours and 1 minute to 60 hours (w/out video)	95719 x 2 and 95717 x 1	95721 x 1	95708 x ~~1~~2 and 95705 x 1	95709 x 2 and 95706 x 1	95710 x 2 and 95707 x 1
50 hours and 1 minute to 60 hours (w/video)	95720 x 2 and 95718 x 1	95722 x 1	95714 x 2 and 95711 x 1	95715 x 2 and 95712 x 1	95716 x 2 and 95713 x 1
60 hours and 1 minute to 74 hours (w/out video)	95719 x 3	95723 x 1	95708 x 3	95709 x 3	95710 x 3

Revise the Long-Term EEG Monitoring Table under the Technical Services, Unmonitored column (4th column) for the row “50 hours and 1 minute to 60 hours (w/out video)” to state 95708 x 2.

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Category I
Medicine
Non-Face-to-Face Nonphysician Services
Qualified Nonphysician Health Care Professional Online Digital ~~Evaluation~~ Assessment and Management Service

Qualified nonphysician health care professional online digital assessment and management ~~evaluation and management~~ services are patient-initiated digital services with qualified nonphysician health care professionals that require qualified nonphysician health care professional patient evaluation and decision making to generate an assessment and subsequent management of the patient. These services are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. While the patient's problem may be new to the qualified nonphysician health care professional, the patient is an established patient. Patients initiate these services through Health Insurance Portability and Accountability Act (HIPAA)-compliant, secure platforms, such as through the electronic health record (EHR) portal, email, or other digital applications, which allow digital communication with the qualified nonphysician health care professional.

Qualified nonphysician health care professional online digital assessments ~~E/M services~~ are reported once for the qualified nonphysician health care professional's cumulative time devoted to the service during a seven-day period. The seven-day period begins with the qualified nonphysician health care professional's initial, personal review of the patient-generated inquiry. Qualified nonphysician health care professional cumulative service time includes review of the initial inquiry, review of patient records or data pertinent to assessment of the patient's problem, personal qualified nonphysician health care professional interaction with clinical staff focused on the patient's problem, development of management plans, including qualified nonphysician health care professional generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email, or other digitally supported communication. All qualified nonphysician health care professionals in the same group practice who are involved in an ~~the~~ online digital assessment ~~E/M services~~ contribute to the cumulative service time devoted to the patient's online digital ~~E/M service~~ assessment. Qualified nonphysician health care professional online digital assessments ~~E/M services~~ requires visit documentation and permanent storage (electronic or hard copy) of the encounter.

If the patient generates the initial online digital inquiry within seven days of a previous treatment or E/M service and both services relate to the same problem, or the online digital inquiry occurs within the postoperative period of a previously completed procedure, then the qualified nonphysician health care professional's online digital assessment ~~E/M services~~ may not be reported separately. If the patient generates an initial online digital inquiry for a new problem within seven days of a previous service that addressed a different problem, then the qualified nonphysician health care professional online digital assessment ~~E/M services~~ is reported separately. If a separately reported evaluation service occurs within seven days of the qualified nonphysician health care professional's initial review of the online digital assessment, codes ~~E/M services,~~ 98970, 98971, 98972 ~~are~~ may not be reported. If the patient presents a new, unrelated problem during the seven-day period of an online digital assessment ~~E/M services~~, then the qualified nonphysician health care professional's time spent ~~on the evaluation and management of the~~ assessing the additional problem is added to the cumulative service time of the online digital assessment ~~E/M services~~ for that seven-day period.

Posted 03/02/2020 T

07/01/2020 T

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●98970 Qualified nonphysician health care professional online digital ~~evaluation and management service~~ assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes ●98971 11-20 minutes ●98972 21 or more minutes **Revise the base portion of the code descriptor for codes 98970, 98971, 98972 to remove “evaluation and management service” and add “assessment and management.”** **Revise the Qualified Nonphysician Health Care Professional Online Digital Evaluation and Management Service subsection by: 1) revising the subsection heading to delete “Evaluation” and add “Assessment”; and 2) revise the introductory guidelines to delete instances of “E/M service” and replace with “assessment” throughout.**	
Category II Codes ▲2022F Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented reviewed; with evidence of retinopathy (DM)[2] ●2023F without evidence of retinopathy (DM)[2] ▲2024F 7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)[2] ●2025F without evidence of retinopathy (DM)[2] ▲2026F Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)[2] #●2033F without evidence of retinopathy (DM)[2] **Indent codes 2023F, 2025F, and 2033F to indicate they are child codes.**	**Posted 11/1/19 E**
Appendix O **Multianalyte Assays with Algorithmic Analyses and Proprietary Laboratory Analyses** MAAA procedures that have been assigned a Category I code are noted in the list below and additionally listed in the Category I MAAA section (~~81500~~81490-81599). The Category I MAAA section introductory language and associated parenthetical instruction(s) should be used to govern the appropriate use for Category I MAAA codes. If a specific MAAA procedure has not been assigned a Category I code, it is indicated as a four-digit number followed by the letter M. When a specific MAAA procedure is not included in either the list below or in the Category I MAAA section, report the analysis using the Category I MAAA unlisted code (81599). The codes below are specific to the assays identified in Appendix O by proprietary name. In order to report an MAAA code, the analysis performed must fulfill the code descriptor **and**, if proprietary, must be the test represented by the proprietary name listed in Appendix O. When an analysis is performed that may potentially fall within a specific descriptor, however the proprietary name is not included in the list below, the MAAA unlisted code (81599) should be used.	**Posted 11/1/19 E**

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Revise the first code in the Category I Multianalyte Assays with Algorithmic Analyses code range in the Appendix O guidelines from code 81500 to 81490.	

Index
Allergen Immunotherapy
 	
Antigens
    Preparation and Provision…………….95144-95165
        Insect Venom……95145-9~~4~~5149
 	
Revise the code listing in the "Insect Venom" subheading following the "Antigens" subheading under the "Allergen Immunotherapy" heading to remove the "4" and add a "5" (ie, 95149) in the Index.
	Posted 11/19/19 E

Index **Angiography** Carotid Artery…..36221, 36222, 36223, 36224, 36225, 36226, 3~~7~~6227, 36228 **Revise the code listing following the "Carotid Artery" subheading under the "Angiography" heading to remove the "7' and add a "6" (ie, 36227) in the Index.**	**Posted 11/19/19 E**
Index **Artery** Coronary Angiography…..93454-93461~~, 92924-92295, 92933, 92934~~ Atherectomy………92924, 92925, 92933, 92934 **Revise the code listing in the "Angiography" subheading following the "Coronary" subheading under the "Artery" heading to remove "92924-92295, 92933, 92934" in the Index.**	**Posted 11/19/19 E**

Index
Cauda Equina
 	
Decompression
    Cervical…..63001, 63015, 63045, 63048
    Lumbar……63005, 63012, 63017, 63087, 63088, 6309~~1~~0-63091, 63047, 63048, 63056, 63057
    Sacral……..63011, 6309~~1~~0-63091
    Thoracic…..63003, 63016, 63087, 63088, 6309~~1~~0-63091, 63046, 63048, 63055, 63057
 	
Revise the code listings in the "Lumbar", "Sacral", and "Thoracic" subheadings following the "Decompression" subheading under the "Cauda Equina" heading to remove the "1" and add a "0" (ie, 63090-63091) in the Index.
	Posted 11/19/19 E

Index **Computer-Assisted Navigation** Cranial Procedure…6~~7~~1781-61782 **Revise the code listing following the "Cranial Procedure" subheading under the "Computer-Assisted Navigation" heading to remove the "7" and add a "1" (ie, 61781) in the Index.**	**Posted 11/19/19 E**

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Index
Drainage
 	
Cyst
    Intramedullary…..63172-6317~~2~~3
…
Syrinx
    Intramedullary…..63172-6317~~2~~3
 	
Revise the code listing in the “Intramedullary” subheadings under the “Cyst” and “Syrinx” subheadings following the “Drainage” heading to remove the “2” and add a “3” (ie, 63173) in the Index.
	Posted 11/19/19 E

Index
Fetal Testing
 	
Ultrasound
    Biophysical Profile…..76818, 76819
    Fetal……76813-7~~3~~6816
 	
Revise the code listing in the “Fetal” subheading following the “Ultrasound” subheading under the “Fetal Testing” heading to remove the “3” and add a “6” (ie, 76816) in the Index.
	Posted 11/19/19 E

Index **Foot** Tendon Lengthening…..2826~~2~~1-28262 **Revise the code listing in the “Lengthening” subheading following the “Tendon” subheading under the “Foot” heading to reverse the order of the “6” and the “2” (ie, 28261) in the Index.**	**Posted 11/19/19 E**

Index
Lung
 	
Empyema
    Drainage…..32035, 32036
    Excision…..32540
    Thoracostomy…..32035-320~~2~~36
…
Thoracostomy
    Empyema…..32035-320~~2~~36
 	
Revise the code listing in the “Thoracostomy” and “Empyema” subheadings following the “Empyema” and “Thoracostomy” subheadings under the “Lung” heading to remove the “2” and add a “3” (ie, 32036) in the Index.
	Posted 11/19/19 E

Index **Pathology and Laboratory** Molecular Pathology…..~~81200-81099~~81105-81408, 81479	**Posted 11/19/19 E**

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Revise the code listing following the “Molecular Pathology” subheading under the “Pathology and Laboratory” heading to remove “81200-81099” and add “81105-81408, 81479” in the Index.	
Index **Radiology** Diagnostic Imaging Heart…..75557-755~~2~~74 **Revise the code listing in the “Heart” subheading following the “Diagnostic Imaging” subheading under the Radiology heading to remove the “2” and add a “7” (ie, 75574) in the Index.**	**Posted 11/19/19 E**
Short Descriptor Data File 98970 QNHP OL DIG ~~E/M SVC~~ ASSMT&MGMT 5-10~~MIN~~ 98971 QNHP OL DIG ~~EM SVC~~ ASSMT&MGMT 11-20~~MIN~~ 98972 QNHP OL DIG ~~E/M SVC~~ ASSMT&MGMT 21+~~ MIN~~ **Revise the short descriptor data file for codes 98970, 98971, 98972.**	**Posted 03/02/2020 T**
Medium Descriptor Data File 37619 ~~INS INTRVAS VC FILTR W/WO VAS ACS VSL SELXN RS&I~~ LIGATION OF INFERIOR VENA CAVA **Revise the medium descriptor data file for code 37619.**	**Posted 08/03/2020 E**
Medium Descriptor Data File 50740 ~~EXC URACHAL CYST/SINUS W/WO UMBILICAL HERNIA RPR~~ URETEROPYELOSTOMY ANAST URETER RENAL PELVIS 81277 CYTOGENOMIC NEOPLASIA MI~~R~~CROARRAY ANALYSIS **Revise the medium descriptor data file for codes 50740 and 81277.**	**Posted 11/1/19 E**
Medium Descriptor Data File 70250 RADIOLOGIC EXAMINATION SKULL 4~~/>~~< VIEWS **Revise the medium descriptor data file for code 70250 to remove “/>” and add “<” for less than 4 views.**	**Posted 03/02/2020 E**
Medium Descriptor Data File 81232 D~~Y~~PYD GENE ANALYSIS COMMON VARIANTS **Revise the medium descriptor data file for code 81232.**	**Posted 03/02/2020 E**
Medium Descriptor Data File 98970 QNHP O~~N~~L~~INE~~ DIGITAL ~~E/M SVC~~ ASSMT&MGMT EST PT <7 D 5-10 MIN	**Posted 03/02/2020 T**

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98971 QNHP O~~NL~~L~~INE~~ DIGITAL ~~E/M SVC~~ ASSMT&MGMT EST PT <7 D 11-20 MIN 98972 QNHP O~~NL~~L~~INE~~ DIGITAL ~~E/M SVC~~ ASSMT&MGMT EST PT <7 D 21+ MIN **Revise the medium descriptor data file for codes 98970, 98971, 98972.**	
Long Descriptor Data File 98970 QUALIFIED NONPHYSICIAN HEALTH CARE PROFESSIONAL ONLINE DIGITAL ~~EVALUATION AND MANAGEMENT SERVICE~~ ASSESSMENT AND MANAGEMENT, FOR AN ESTABLISHED PATIENT, FOR UP TO 7 DAYS, CUMULATIVE TIME DURING THE 7 DAYS; 5-10 MINUTES 98971 QUALIFIED NONPHYSICIAN HEALTH CARE PROFESSIONAL ONLINE DIGITAL ~~EVALUATION AND MANAGEMENT SERVICE~~ ASSESSMENT AND MANAGEMENT, FOR AN ESTABLISHED PATIENT, FOR UP TO 7 DAYS, CUMULATIVE TIME DURING THE 7 DAYS; 11-20 MINUTES 98972 QUALIFIED NONPHYSICIAN HEALTH CARE PROFESSIONAL ONLINE DIGITAL ~~EVALUATION AND MANAGEMENT SERVICE~~ ASSESSMENT AND MANAGEMENT, FOR AN ESTABLISHED PATIENT, FOR UP TO 7 DAYS, CUMULATIVE TIME DURING THE 7 DAYS; 21 OR MORE MINUTES **Revise the long descriptor data file for codes 98970, 98971, 98972 to remove "evaluation and management service" and add "assessment and management."**	**Posted 03/02/2020 T**
Long Descriptor Data File 99489 COMPLEX CHRONIC CARE MANAGEMENT SERVICES, WITH THE FOLLOWING REQUIRED ELEMENTS: MULTIPLE (TWO OR MORE) CHRONIC CONDITIONS EXPECTED TO LAST AT LEAST 12 MONTHS, OR UNTIL THE DEATH OF THE PATIENT, CHRONIC CONDITIONS PLACE THE PATIENT AT SIGNIFICANT RISK OF DEATH, ACUTE EXACERBATION/DECOMPENSATION, OR FUNCTIONAL DECLINE, ESTABLISHMENT OR SUBSTANTIAL REVISION OF A COMPREHENSIVE CARE PLAN, MODERATE OR HIGH COMPLEXITY MEDICAL DECISION MAKING; ~~60 MINUTES OF CLINICAL STAFF TIME DIRECTED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, PER CALENDAR MONTH.;~~ EACH ADDITIONAL 30 MINUTES OF CLINICAL STAFF TIME DIRECTED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, PER CALENDAR MONTH (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) **Revise the long descriptor data file to remove the extension "60 MINUTES OF CLINICAL STAFF TIME DIRECTED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, PER CALENDAR MONTH.;" in the long descriptor for code 99489.**	**Posted 01/31/2020 E**
Illustrations **Punch Biopsy of Skin** **11104, 11105**	**Posted 11/1/19 E**

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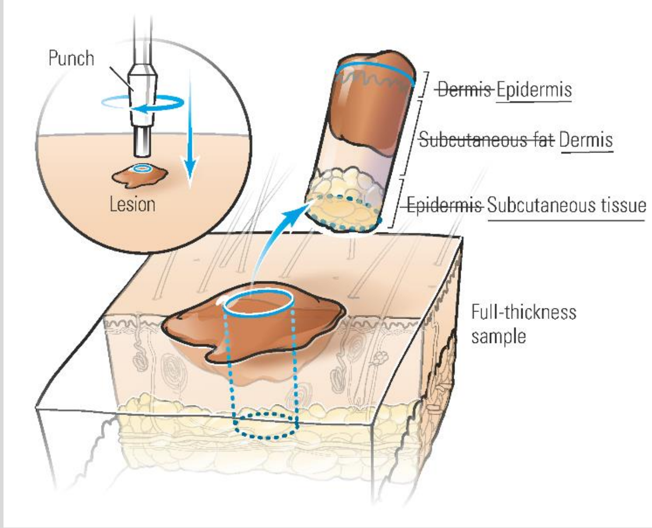
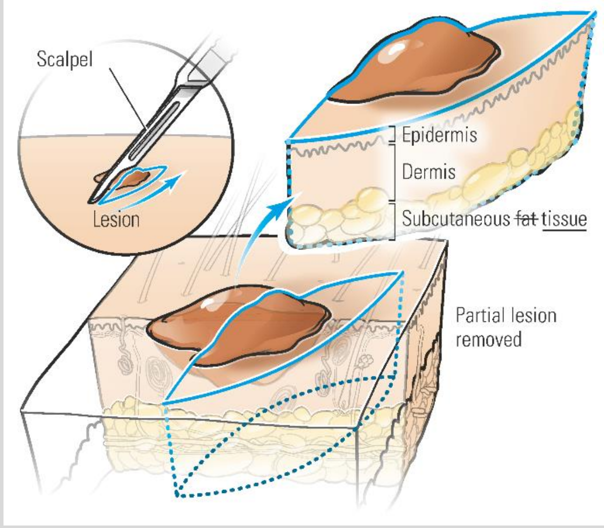


Incisional Biopsy of Skin
11106, 11107



Excision of Lesion
11400 and 11600 series

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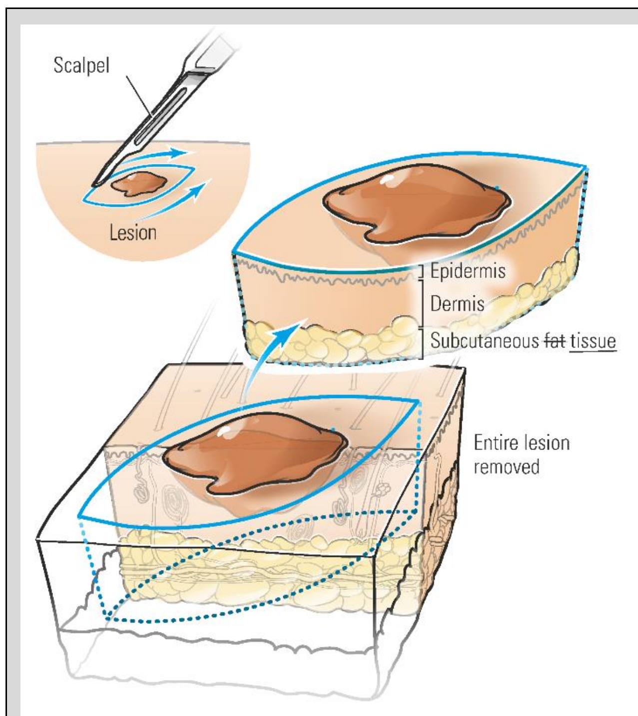 **Revise Integumentary System illustrations to: 1) correctly label the layers of skin and revise "subcutaneous fat" to "subcutaneous tissue" in the Punch Biopsy of Skin (11104, 11105) illustration; and 2) revise "subcutaneous fat" to "subcutaneous tissue" in the Incisional Biopsy of Skin (11106, 11107) and Excision of Lesion (11400 and 11600 series) illustrations.**	

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