guidewire and the balloon are confirmed endoscopically during the course of the placement of each. The balloon is then inflated, resulting in dilation of the natural ostium of the sinus, displacing bone and mucosa. After dilation, the balloon is deflated and removed. In some cases, a separate catheter can be introduced over the guidewire for irrigation of the sinus.

**Larynx**

**Excision**

31390  Laryngotomy (thyrotomy, laryngofissure), with removal of tumor or laryngcele, colectomy (31320 has been deleted)

31390  Laryngectomy; total, without radical neck dissection

31365  total, with radical neck dissection

**Rationale**

Code 31320 (laryngotomy [thyrotomy, laryngofissure]; diagnostic) has been deleted due to low utilization and to ensure that the CPT code set reflects current clinical practice.

**Trachea and Bronchi**

**Endoscopy**

31622  Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)

31643  with placement of catheter(s) for intracavitary radionuclide application

(For intracavitary radionuclide application, see 77761-77763, 77778, 77771, 77772)

31645  with therapeutic aspiration of tracheobronchial tree, initial

31646  with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay

(For catheter aspiration of tracheobronchial tree with fiberscope at bedside, use 31725)

• 31654  with transcatheter bronchoscopic ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s)

(Use 31654 in conjunction with 31622, 31623, 31624, 31625, 31626, 31628, 31629, 31640, 31643, 31645, 31646)

**Clinical Example (31645)**

A 60-year-old male has been hospitalized for one week for respiratory failure. He has respiratory decompensation, oxygen requirements have increased, and a chest radiograph shows new lung atelectasis. Bronchoscopy is performed for the clearance of secretions that are obstructing bronchi.

**Description of Procedure (31645)**

The physician evaluates for the appropriate topical anesthesia and moderate sedation. O2 is evaluated to maintain normal O2 saturations throughout procedure. A flexible bronchoscope is inserted through the mouth or nostril to visualize the upper airways to the vocal cords. The vocal cords are observed for function. The bronchoscope is then advanced into the trachea. All airways are inspected. Secretions are identified and aspirated. All segments of the lung are visualized, and each segment is aspirated, as needed, to clear secretions. Sterile saline may be required to mobilize more viscous and distal secretions. The bronchoscope is removed, and the inner channel is flushed, as necessary, to clear more tenacious secretions. The bronchoscope is reintroduced, as necessary, until the secretions are clear. The physician examines the patient immediately post-endoscopy to ascertain that no complication, such as desaturation or respiratory failure, has occurred.
Evaluation and Management

Hospital Observation Services

Observation Care Discharge Services

- **99217** Observation care discharge day management. (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital “observation status” if the discharge is on other than the initial date of “observation status.” To report services to a patient designated as “observation status” or “inpatient status” and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate].)

- **99220** Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components:
  - A comprehensive history;
  - A comprehensive examination; and
  - Medical decision making of moderate complexity.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the problem(s) requiring admission to outpatient hospital “observation status” are of moderate severity. Typically, 59 minutes are spent at the bedside and on the patient’s hospital floor or unit.

Initial Observation Care

New or Established Patient

The following codes are used to report the encounter(s) by the supervising physician or other qualified health care professional with the patient when designated as outpatient hospital “observation status.” This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments. For observation encounters by other physicians, see office or other outpatient consultation codes (99241-99245) or subsequent observation care codes (99224-99226) as appropriate.

- **99218** Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components:
  - A detailed or comprehensive history;
  - A detailed or comprehensive examination; and
  - Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the problem(s) requiring admission to outpatient hospital “observation status” are of low severity. Typically, 30 minutes are spent at the bedside and on the patient’s hospital floor or unit.

- **99219** Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components:

Rationale

Codes 99217, 99218, 99219, and 99220 have been editorially revised by adding the term “outpatient hospital” in front of “observation status” in the code descriptor, in order to better align the CPT code set with other nomenclatures. This revision affects only the description of the site of service, therefore, it does not affect how these codes are used or reported because no service changes have been made to the code descriptor.

Critical Care Services

Critical care is the direct delivery by a physician(s) or other qualified health care professional of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition. Examples of vital