



2011 CPT Update

Corlis Schafer, RHIT, CCS-P, CCS
Compliance Resource Manager

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Physician Fee Schedule Oversight

▶ Major changes:

1. Group practice must notify Medicare beneficiaries of alternative advanced imaging suppliers.
2. Providers have a shortened (12 month) time period for submitting Medicare claims. There are certain exceptions to this rule.
3. Requisitions for Laboratory tests paid under the Clinical Fee Schedule now must be signed by a physician or non-physician practitioner (NPP). (IOM, 100-02, Chapter 15, Section 80.6.1)
4. The Affordable Care Act requires CMS to establish a value-based payment modifier to pay physicians on a differential basis, based both on quality of care and costs of care using composites of both quality and cost measures. Modifier is to be phased in from January 1, 2015 through January 1, 2017.

<http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf>

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Physician Fee Schedule

- ▶ 2009 physician fee schedule rates continued through May, 2010
- ▶ June 2010 through November 2010 rates increased by 2.2 percent update - \$36.8729
- ▶ December 2010 conversion factor was \$28.3868

▶ **Conversion factor for 2011 is \$25.5217**

▶ <http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf>

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Physician Fee Schedule - Anesthesiology

- ▶ 2010 Conversion factor through November was \$21.53
- ▶ December 2010 conversion factor was \$16.6058.
- ▶ 2011 Conversion factor for Anesthesiology is \$15.8085
- ▶ <http://www.trailblazerhealth.com/Publications/Fee%20Schedule/2011ACF.pdf>
- ▶ <http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf>

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Resources

- ▶ Pricing amounts; various payment policy indicators; RVUs; and GPCIs by a single procedure code, a range, and a list of procedure codes can be accessed via the Physician Fee Schedule Look-Up located at <http://www.cms.gov/Pfslookup> on the CMS website.
- ▶ Additional information about the PFS can be accessed at http://www.cms.gov/PhysicianFeeSched/01_overview.asp on the CMS website.

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Certified Nurse-Midwife Services

- ▶ Currently, CNM services pay 80 percent of the lesser actual charge or 65 percent of the PFS for the same service furnished by a physician.
- ▶ Effective January 1, 2011, Medicare payment will be 100 percent of the PFS amount for the same service furnished by a physician (or 80 percent of the actual charge if that is less).
- ▶ Part B will pay CNMs for professional services in all settings, as well as services and supplies furnished incident to those services.
- ▶ No supervision or oversight requirement of CNMs.
- ▶ CNMs are authorized to personally furnish diagnostic tests that fall under their State scope of practice.

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Annual Wellness Visit

- ▶ This benefit is not subject to the “incident to” rules.
- ▶ This visit may be performed by a “team of medical professionals working under the supervision of a physician.”
- ▶ It is the supervising physician who would bill Medicare for the visit.
- ▶ This visit would be furnished under “direct supervision” of a physician.
- ▶ <http://www.cms.gov/MLN MattersArticles/downloads/MM7079.pdf>
- ▶ <http://www.cms.gov/Transmittals/downloads/R2109CP.pdf>

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Removal of Barriers to Preventive Services In Medicare

- ▶ Section 4103 of the Affordable Care Act (ACA) defined preventive services for Medicare to include:
 - ▶ Initial preventive physical exam (IPPE)
 - ▶ Annual wellness visits and
 - ▶ Allows Medicare to add other preventive services to the extent consistent with the United States Preventive Task Force (USPSTF).
 - ▶ Other preventive services already listed in the statute
 - ▶ G0438 – First visit
 - ▶ G0439 – Subsequent visit
 - ▶ Use -25 modifier if a separately identifiable E/M service is provided on the same day.

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Annual Wellness Visit (AWV)

- ▶ Includes a health risk assessment (HRA) and creates a personalized prevention plan (PPP).
 - ▶ 1. Establish or update an individual medical and family history;
 - ▶ 2. List current providers and suppliers and medications prescribed for the individual;
 - ▶ 3. Measurements of height, weight, BMI or waist circumference, BP;
 - ▶ 4. Detection of any cognitive impairment, establish or update an appropriate screening schedule for the next 5-10 years;
 - ▶ 5. Voluntary advance care planning;
 - ▶ 6. Establish or update list of risk factors and condition (including mental health condition; and
 - ▶ 7. Furnish personalized health advice and referral as appropriate, to health education or prevention counseling services or programs.

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Other Preventive Services

- ▶ Vaccine administration (pneumococcal, influenza, and Hepatitis B)
- ▶ Screening mammography
- ▶ Screening pap smear and pelvic exams
- ▶ Prostate cancer screening
- ▶ Bone mass measurement
- ▶ Diabetes outpatient self-management training services
- ▶ Glaucoma screening
- ▶ Medical Nutrition Therapy for diabetes or renal disease
- ▶ Cardiovascular screening blood tests
- ▶ Diabetes screening tests

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Removal of Barriers to Preventive Services

- ▶ Waives deductible and coinsurance for those preventive services that receive a grade of A or B by USPSTF
- ▶ Not all preventive services provided in a statute receive grade A or B
- ▶ Deductible and coinsurance already specified in statute for some services:
 - ▶ Laboratory tests have no deductible or coinsurance
 - ▶ Influenza, pneumococcal have no deductible or coinsurance
 - ▶ Screening mammography, screening pelvic exams, colorectal cancer screening, ultrasound screening for AAA and IPPE no deductible but coinsurance applies.
- ▶ <http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm>

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Medicare Telehealth Services

- ▶ CMS proposed the following services be added to the Telehealth benefit:
- ▶ G0420 – Individual KDE Services
- ▶ G0108 – Individual DSMT Services
- ▶ Group KDE, MNT, DSMT and HBAI Services
- ▶ Subsequent hospital care and nursing facility care services
- ▶ Read CR 7049 for policy instructions to the Medicare Claims Processing Manual and the Medicare Benefit Policy Manual at <http://www.cms.gov/Transmittals/downloadsR2032CP.pdf>
- ▶ Medicare Learning Network (MLN): <http://www.cms.gov/MLN MattersArticles/downloads/MM7049.pdf>

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Medicare Telehealth Services

- ▶ Subsequent Hospital Care Services: 99231, 99232, 99233
- ▶ Added to the list of Telehealth services, subject to the limitations on frequency – not more than once every 3 days.
- ▶ Subsequent Nursing Facility Care Services (99307-99310)
- ▶ Added to the list of Telehealth services for use by the admitting physician, subject to the limitations on frequency – not more than once every 30 days.
- ▶ 42 CFR 410.78(e)(2) Section §483.40(c)

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Canalith Repositioning Procedure

95992 Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day

- ▶ Effective January 1, 2011, CMS will recognize 95992 for payment under the Physician Fee Schedule.

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Diagnostic Colorectal Cancer Screening

- ▶ Waiver of Part B deductible – Providers must append HCPCS modifier PT (Colorectal cancer screening test, converted to diagnostic test or other procedure) to the diagnostic procedure code reported **instead of** the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code.
- ▶ Co-insurance will continue to apply to the diagnostic test and other services.

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“0” day Global Services

- ▶ I1043 (Debridement, muscle and/or fascia; first 20 sq cm of less) had a 90 day global period
- ▶ I1044 (Debridement, bone; first 20 sq cm or less), had a 90 day global period
- ▶ Due to issues with survey vignettes, variations in length of stay, the RUC requested CMS change the global to “0 days.”
- ▶ CMS agreed.

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CMS Introduces New G-Codes

- G0440 Application of tissue cultured allogenic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; first 25 sq cm or less
- G0441 Application of tissue cultured allogenic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; each additional 25 sq cm
- ▶ **0 global days**

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E/M, Vaccines and Time Based Codes



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E/M, Vaccines and Time Based Codes

- ▶ Subsequent Observation Care (new codes)
- ▶ Pediatric Critical Transport (bundled services)
- ▶ Psychiatry (Consult instructions)
- ▶ Time
- ▶ Preventive Medicine Services (Separate reporting)
- ▶ Pediatric Vaccine Administration/Vaccines

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Subsequent Observation Care

- ▶ **Problem**
 - ▶ Office and Other Outpatient E/M in a “hospital” setting
 - ▶ Administration of Insurance Benefits (office visit copays)
- ▶ **Solution**
 - ▶ Create codes that match subsequent hospital care
- ▶ **Rationale**
 - ▶ Existing Observation Codes had structure and value close to hospital inpatient services

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Subsequent Observation Care Codes

- # ● **99224** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components
 - ▶ Problem focused interval history;
 - ▶ Problem focused examination;
 - ▶ Medical decision making that is straightforward or of low complexity.
- ▶ **Counseling and/or coordination of care...**
- ▶ **Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient’s hospital floor or unit.**

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Subsequent Observation Care Codes

- # ● **99225** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components
 - ▶ An expanded problem focused interval history;
 - ▶ An expanded problem focused examination;
 - ▶ Medical decision making of high complexity.
- ▶ **Counseling and/or coordination of care...**
- ▶ **Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient’s hospital floor or unit.**

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Subsequent Observation Care Codes

- # ● **99226** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components
 - ▶ A detailed interval history;
 - ▶ A detailed examination;
 - ▶ Medical decision making of high complexity.
- ▶ **Counseling and/or coordination of care...**
- ▶ **Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient’s hospital floor or unit.**

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Subsequent Observation and Inpatient

OBS	Key Components (2/3) Time	INPATIENT	Key Components (2/3) Time
99224	PF/PF/SF-L 15	99231	PF/PF/SF-L 15
99225	EPF/EPF/M 25	99232	EPF/EPF/M 25
99226	D/D/H 35	99233	D/D/H 35

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Subsequent Observation Care Codes

▶ When does subsequent observation care begin?

▶ Answer:

▶ After the initial observation care date of service.

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Things to Remember

- ▶ Do not report a subsequent observation care code on the same day with an initial observation care code.
- ▶ Observation care discharge services and subsequent observation may not be reported on the same day
- ▶ Do not report observation services on the same day as office or emergency department services
- ▶ For a patient admitted and discharged for observation or inpatient status on the same date, use 99234-99236 as appropriate.

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Clinical Example

▶ 7:00 a.m. Thursday morning

- ▶ 23-year-old female with nausea, vomiting, and crampy abdominal pain presents to the emergency department, is evaluated and admitted to observation status. The attending physician does not feel she can be discharged that date and reports 99219, Initial Observation Care. A surgical consult is requested and the surgeon reports 99244, Office Consultation.

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Clinical Example (cont'd)

- ▶ 7:00 a.m. Friday morning
- ▶ The patient is responding to therapy. Although the patient's condition has improved, there are concerns regarding the abdominal condition, requiring continued observation.
- ▶ She is seen by both her attending physician and the surgeon. Both report 99225, Subsequent Observation Care
- ▶ 8:00 a.m. Saturday morning
- ▶ The patient has responded adequately for discharge. The attending reports 99217, observation care discharge services.

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Typical Times

- ▶ Unlike other Observation codes, these have typical times
- ▶ Prolonged Services codes are 99356, 99357
 - ▶ Observation is not technically inpatient, but
 - ▶ Unit/floor time is used

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Medicare Consultation on Observation Status Patients

- ▶ **QUESTION:** Will 99224-99226 be used for initial contact services when they are the most appropriate codes based on CMS rules for reporting consults and based upon CPT descriptor for level of service?
- ▶ **ANSWER:** Yes, use subsequent observation codes.

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Psychiatry (Follow-up Visits – 99241-99255)

- ▶ (99241-99255) are limited to initial ~~or follow-up~~ evaluation and **do not** involve psychiatric treatment.
- ▶ Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant or patient are reported using the appropriate codes for established patients,
 - ▶ office visits (99211-99215),
 - ▶ domiciliary, rest home (99334-99337),
 - ▶ or home (99347-99350).

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Time

- ▶ Creates general rules for codes that do not specify rules
- ▶ Restates office and outpatient typical times as face-to-face; inpatient hospital, nursing facility and subsequent observation times as unit/floor
- ▶ Defines rules for services that start on one calendar date and continue on another

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Medical Genetics and Genetic Counseling Services

96040 Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family

- ▶ Code 96040 is reported for each 30 minute increment of face-to-face time. Do not report 96040 for 15 minutes or less of face-to-face time. Report 96040 once for 16 to 30 minutes of face-to-face time.

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Preventive Medicine

- ▶ Revision of text to clarify existing policy:
- ▶ Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests (eg, vision, hearing, developmental) identified with a specific CPT code are reported separately. For immunization administration and vaccine risk/benefit counseling, see 90460, 90461, 90470-90474. For vaccine/toxoid products, see 90476-90749.

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Immunization Administration for Vaccines/Toxoids

- ▶ Codes 90465, 90466, 90467 and 90468 have been deleted and replaced with new immunization administration codes 90460 and 90461 for patients 18 years of age and under who receive counseling.
 - 90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component.
 - + ● 90461 each additional vaccine/toxoid component (List separately in addition to code for primary procedure)

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Coding for a 2-month-old infant based on the current immunization schedule

DTaP (IM):	Admin: 90460, 90461, 90461
Rotavirus (oral)	Admin: 90460 Vaccine: 90681
Hepatitis B and Haemophilus influenza type b (IM)	Admin: 90460, 90461 Vaccine: 90748
Inactivated Poliovirus (IM)	Admin: 90460 Vaccine: 90713
Pneumococcal conjugate vaccine, 13 valent (IM)	Admin: 90460 Vaccine: 90670

TOTAL: 90460 x 5 and 90461 x 3

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New Recommendations for the 2010/2011 Flu Season

- ▶ H1N1 products (90663) developed for the 2009 H1N1 pandemic have expired and should not be administered.
- ▶ Reformulated seasonal flu vaccines which incorporate the H1N1 virus and related viruses should be reported with the seasonal influenza vaccine codes (90655 et al) and vaccine administration codes (90460, 90461, 90471-90474) **AND NOT** 90663 and 90470.

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Series of Codes added for potential future pandemic

- 90664 Influenza virus vaccine, pandemic formulation, live, for intranasal use
- 90666 Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use
- 90667 Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use
- 90668 Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use

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FDA Approval Received

- ▲ 90650 Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 doses schedule, for intramuscular use
- ▲ 90662 Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
- ▲ 90670 Pneumococcal conjugate vaccine, 13 valent, for intramuscular use

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1 New Vaccine Product Code Added

- 90644 Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine, tetanus toxoid conjugate (Hib-MenCY-TT), 4 dose schedule, when administered to children 2-15 months of age, for intramuscular use.

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GENERAL SURGERY



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Excision - Debridement

- ▶ Wound debridement (11042-11047) are reported by depth of tissue that is removed and by surface area of the wound. These services may be reported for injuries, infections, wounds and chronic ulcers. ~~These services are reported when the intent is not to perform a primary closure (see 15002-15002), except when debridement is related to a repair which is the primary intent of the service (see Repair guidelines), or when no more specific codes are available.~~ When performing debridement of a single wound, report depth using the deepest level of tissue removed. In multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths.

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Excision - Debridement (cont'd)

- ▶ For example: When bone is debrided from a 4 sq cm heel ulcer and from a 10 sq cm ischial ulcer, report the work with a single code, 11044. When subcutaneous tissue is debrided from a 16 sq cm dehisced abdominal wound and a 10 sq cm and 11045 for the second 6 sq cm. If all four wounds were debrided on the same day, use modifier 59 with 11042, 11045 and 11044.

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~~Excision~~ – Debridement (cont'd)

- ▲ I1010 Debridement including removal of foreign material ~~associated with~~ at the site of an open fracture(s) (eg, excisional debridement); skin and subcutaneous tissues
- ▲ I1011 skin, subcutaneous, muscle fascia, and muscle
- ▲ I1012 skin, subcutaneous tissue, muscle fascia, muscle, and bone

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Debridement (cont'd)

- ▶ (I1040, I1041 have been deleted)
- ▶ (For debridement of skin, ie, epidermis and/or dermis only, see 97597, 97598)
- ▲ I1042 Debridement, skin, and subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
- + ● I1045 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
- ▶ (Use I1045 in conjunction with I1042)

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Debridement (cont'd)

- ▲ I1043 Debridement, skin, subcutaneous tissue, and muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
- #+ ● I1046 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
- ▶ (Use I1046 in conjunction with I1043)
- I1043 has “0” global days!

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Debridement (cont'd)

- ▲ I1044 Debridement, skin, subcutaneous tissue, muscle, and bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
- #+ ● I1047 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
- ▶ (Do not report I1042-I1047 in conjunction with 97597-97602 for the same wound)
- ▶ (Use I1047 in conjunction with I1044)
- I1044 now has “0” global day!

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Active Wound Care Management

- ▲ 97597 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area; less than or equal to first 20 sq cm or less

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Active Wound Care Management (cont'd)

- + ▲ 97598 ~~total wound(s) surface area greater than each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)~~

▶ (Use 97598 in conjunction with 97597)

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Skin Replacement Surgery and Skin Substitutes

- ▶ *Repair of donor site requiring skin graft or local flaps is to be added as an additional procedure.*

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Surgical Preparation Guidelines (cont'd)

- ▶ Skin Replacement Surgery and Skin Substitute guidelines
- ▶ Have been expanded to include two subheadings:
- ▶ “Surgical Preparation” and “Application of Skin Replacements and Skin Substitutes” procedures and services.

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Surgical Preparation Guidelines

- ▶ Codes I5002-I5005 describe the services related to preparing a clean and viable wound surface for placement of a graft, flap, skin replacement, skin substitute or negative pressure wound therapy. In some cases, closure may be possible using adjacent tissue transfer (I4000-I4061) or complex repair (I3100-I3153). In all cases, appreciable nonviable tissue is removed to treat a burn, traumatic wound or a necrotizing infection. The clean wound bed may also be created by incisional release of a scar contracture resulting in a surface defect from separation of tissues.

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Fiducial Marker Placement

- 49321 Laparoscopy, surgical; with biopsy (single or multiple)
- ▲ 49324 with insertion of tunneled intraperitoneal cannula or catheter, permanent
- + ● 49327 with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retro-peritoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)

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Fiducial Marker Placement (cont'd)

- + ● 49412 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)

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Fiducial Marker Placement (cont'd)

- ▲ 55876 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), ~~percutaneous~~, prostate (via needle, any approach), single or multiple

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Intraperitoneal Catheter

- 49418 Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous
- ▲ 49419 Insertion of tunneled intraperitoneal cannula or catheter, with subcutaneous port reservoir, permanent (ie, totally implantable)

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Intraperitoneal Catheter (cont'd)

(49420 has been deleted. To report open placement of a tunneled catheter for dialysis, use 49421. To report open or percutaneous peritoneal drainage, see 49060, 49061, 49062, 49080, 49081, as appropriate. To report percutaneous insertion of tunneled catheter, use 49418.

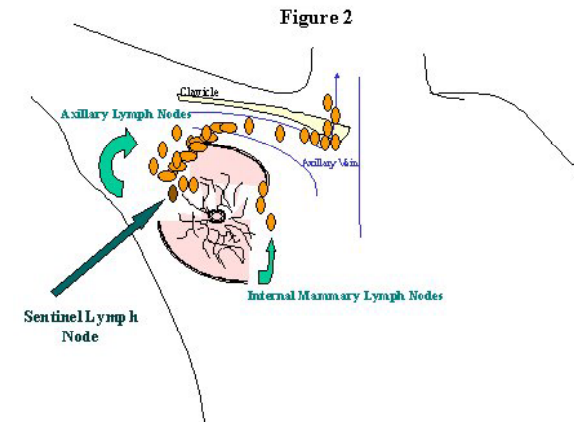
- ▲ 49421 Insertion of tunneled intraperitoneal ~~cannula or~~ catheter for ~~drainage of~~ dialysis; ~~permanent,~~ open

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Intraperitoneal Catheter (cont'd)

- ▶ (For laparoscopic insertion of tunneled permanent intraperitoneal ~~cannula or~~ catheter, use 49324) ◀
- ▲ 49422 Removal of tunneled permanent intraperitoneal ~~cannula or~~ catheter
- ▶ (For removal of a non-tunneled temporary catheter/~~cannula~~, use appropriate E/M code) ◀

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▶ 60

Sentinel Lymph Node Mapping

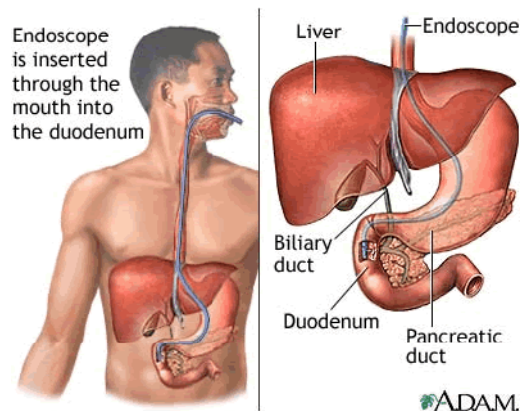
- + ● 38900 Intraoperative identification (eg, mapping) of sentinel lymph nodes(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)
- ▶ (Use 38900 in conjunction with 19302, 19307, 38500, 38510, 38520, 38525, 38530, 38542, 38740, 38745) ◀
- ▶ (For injection of radioactive tracer for identification of sentinel node, use 38792) ◀

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Sentinel Lymph Node Mapping (cont'd)

- ▶ Again, capture work done without mechanism to report
- ▶ No current code to describe the work of mapping
- ▶ Mapping includes injection of dye, if performed
- ▶ Currently 38792 only describes injection; mapping is new work described in 38900
- ▶ Does not include injection of radioisotope
- ▶ Does include mapping of radioactive isotope
- ▶ Confused....don't be ☺

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Gastrointestinal

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Digestive System Esophagus

- 43327 Esophagogastric fundoplasty partial or complete; laparotomy
- 43328 thoracotomy
- 43332 Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis
- 43333 with implantation of mesh or other prosthesis
- ▶ (For neonatal diaphragmatic hernia repair, use 39503) ◀

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Digestive System Esophagus (cont'd)

- 43334 Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis
- 43335 with implantation of mesh or other prosthesis
▶ (For neonatal diaphragmatic hernia repair, use 39503) ◀
- 43336 Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis
- 43337 with implantation of mesh or other prosthesis
▶ (For neonatal diaphragmatic hernia repair, use 35903) ◀

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Digestive System Esophagus (cont'd)

- + ● 43338 Esophageal lengthening procedure (eg Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for basic service)
- ▶ (Use 43338 in conjunction with 43280, 43327-43337) ◀

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Digestive System Stomach

~~43600 — Biopsy of stomach; by capsule, tube, peroral (1 or more specimens)~~

- ▲ 43605 Biopsy of stomach, by laparotomy

Capsule biopsy obsolete; 43605 code becomes parent code

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Gastroenterology Changes

- 43753 Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill (eg, for gastrointestinal hemorrhage), including lavage if performed
- 43754 Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)
- 43755 collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin), includes drug administration
- ▶ (For gastric acid analysis, use 82930) ◀
- ▶ (For naso- or oro-gastric tube placement by physician with fluoroscopic guidance, use 43752) ◀

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Gastroenterology Changes

- 43756 Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (eg, bile study for crystals or afferent loop culture)
- 43757 collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration
- ▶ (For appropriate chemical analysis procedures, see 89049 – 89240) ◀
- ▶ (Report the substance[s] or drug[s] administered. The fluid used to administer the drug[s] is not separately reported) ◀

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Gastroenterology Changes

- ▶ Medicine Section
 - ~~91000 Esophageal intubation and collection of washings for cytology, including preparation of specimens (separate procedure)~~
 - ▲ 91010 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; 2 dimensional data
 - ~~91011 with mecholyl or similar stimulant~~
 - ~~91012 with acid perfusion studies~~
 - ▶ (To report 91011, 91012, esophageal motility studies with stimulant or perfusion, use 91013) ◀

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Gastroenterology Changes

- + ● 91013 with stimulation or perfusion during 2-dimensional data study (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)
- ▶ (Use 91013 in conjunction with 91010) ◀
- ▶ (Do not report 91013 more than once per session) ◀
- ▶ (91052, 91055 have been deleted. To report, see 43754, 43755) ◀
- ▶ (91105 has been deleted. To report, use 43753) ◀

▶ 71

Gastroenterology Changes

- 91117 Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed) with interpretation and report
- ▶ (Do not report 91117 in conjunction with 91120, 91122) ◀
- 91120 Rectal sensation, tone, and compliance test (ie, response to graded balloon distention)
- 91122 Anorectal manometry
- ▶ (Do not report 91120, 91122 in conjunction with 91117) ◀
- ▶ (91123 has been deleted) ◀

▶ 72

Esophageal pH Monitoring

- 91034 Esophagus, gastroesophageal reflux test with nasal catheter pH electrode(s) placement, recording, analysis and interpretation
- 91035 with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation

Placement of the mucosal attached capsule is a part of the procedure and reimbursement for 91035.

If the endoscopy is performed to examine the esophagus to the duodenum for abnormalities, it can be billed together with the placement of the capsule with a 59 modifier on the endoscopy (43235-59).

Endoscopy only to place device is not reportable.

▶ 73

Incomplete Colonoscopy: 2011 Clarification

- ▶ ~~For an incomplete colonoscopy, with full preparation for a colonoscopy, use a colonoscopy code with the modifier 52 and provide documentation.~~
- ▶ When performing an endoscopy on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscopy beyond the splenic flexure, due to unforeseen circumstances, report the colonoscopy code with modifier 53 and appropriate documentation.
- ▶ Applies to all payors: Medicare and commercial

▶ 74

Retrograde Enteroscopy

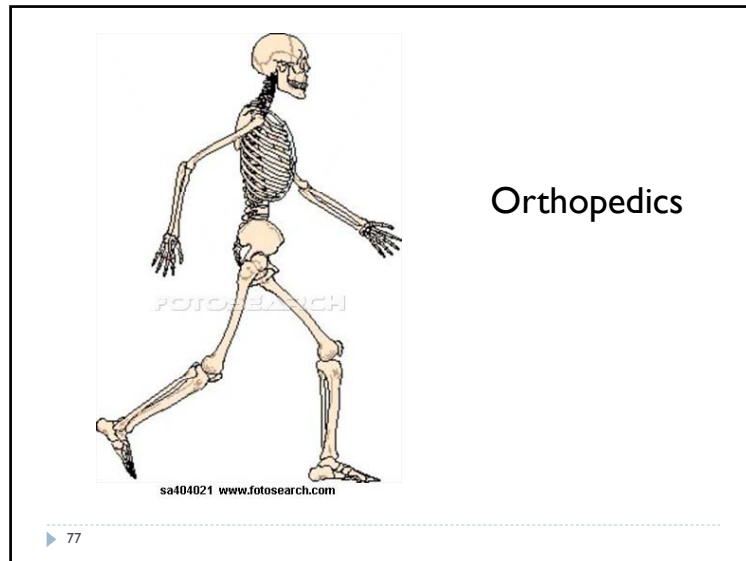
- ▶ **Introduction language:** *Colonoscopy* is the examination of the entire colon, from the rectum to the cecum, and may include the examination of the terminal ileum.
- ▶ This is incidental or distal 20 cm eg. Assessment of ileitis, uses standard colonoscopy, “intent is limited”
- ▶ Enteroscopy is extended exam of ileum performed “beyond” range of standard colonoscopy; *different equipment, skills, work, time...; different intent*
SO code as unlisted 44799 itself as entire procedure or in addition to colonoscopy 45378 when colon is examined in addition to retrograde enteroscopy.

▶ 75

Endoluminal Functional Lumen Imaging

- ▶ FDA: Gastrointestinal motility monitoring system: “The device is intended to estimate the size of the stoma produced by the gastric band in a clinical setting.”
- ▶ Coding: Is this equivalent to 91020 (gastric motility) or an unlisted code 91299?

▶ 76



Musculoskeletal System

- 20000 Incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial
 - ▶ (For incision and drainage procedures, cutaneous / subcutaneous, see 10060, 10061) ◀
 - ▲ 20005 Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia) deep or complicated
- ▶ 78

Musculoskeletal System

26596 Excision of constricting ring of finger, with multiple Z-plasties

- ▶ (To report release of scar contracture or graft repairs, see 11042, 14040 – 14041, or 15120, 15240) ◀
- ▶ 79

Orthopedics – Pelvis and Hip Joint

- ▲ 27065 Excision of bone cyst of benign tumor, wing of ilium, symphysis pubis, or greater trochanter of femur; superficial, ~~(wing of ilium, symphysis pubis, or greater trochanter of femur)~~ with or without includes autograft, when performed
 - ▲ 27066 deep (subfascial), with or without includes autograft, when performed
 - ▲ 27067 with autograft requiring separate incision
- ▶ 80

Orthopedics – Pelvis and Hip Joint

- ▲ 27070 Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur; (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial (~~eg, wing of ilium, symphysis pubis or greater trochanter of femur~~)
- ▲ 27071 Deep (subfascial or intramuscular)

▶ 81

Orthopedics – Endoscopy/Arthroscopy

- # ● 29914 Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)
- # ● 29915 with acetabuloplasty (ie, treatment of pincer lesion)
- ▶ (Do not report 29914, 29915 in conjunction with 29862, Arthroscopy, hip surgical; with debridement/ shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum, or 29863 Arthroscopy, hip, surgical; with synovectomy) ◀

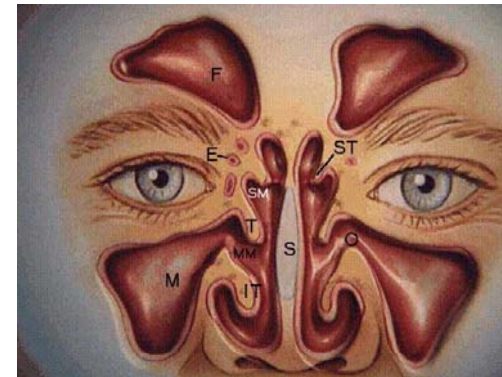
▶ 82

Orthopedics – Endoscopy/Arthroscopy

- # ● 29916 Arthroscopy, hip, surgical; with labral repair

▶ (Do not report 29916 for labral repair secondary to acetabuloplasty or in conjunction with 29862, 29863) ◀

▶ 83



Otolaryngology

▶ 84

Deletion +61795, New Cranial & Extradural

- +●61781 Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)
- ▶(Do not report 61781 in conjunction with 61720-61791, 61796-61799, 61863-61868, 62201, 77371-77373, 77432)◀
- +●61782 cranial, extradural (List separately in addition to code for primary procedure)
- ▶(Do not report 61781, 61782 by the same provider during the same surgical session)◀
- +●61783 spinal (List separately in addition to code for primary procedure)
- ▶(Do not report 61783 in conjunction with 63620, 63621)◀

▶ 85

+61782 Stereotactic Computer-assisted (Navigational) procedure; cranial, extradural

- ▶ Revision sinus surgery.
- ▶ Distorted sinus anatomy of development, postoperative, or traumatic origin.
- ▶ Extensive sino-nasal polyposis.
- ▶ Pathology involving the frontal, posterior ethmoid and sphenoid sinuses.
- ▶ Disease abutting the skull base, orbit, optic nerve, or carotid artery.
- ▶ CSF rhinorrhea or conditions where there is a skull base defect.
- ▶ Benign and malignant sino-nasal neoplasms.

▶ 86

+61782 Stereotactic Computer-assisted (Navigational) procedure; cranial, extradural

- ▶ Head frame or other hardware is affixed to the patient's head, taking care to precisely position the apparatus
- ▶ Surface tracings of the head and facial regions are performed to register and calibrate the device.
- ▶ Verification of navigational accuracy is ascertained by correlating specific surface anatomic sites to the computer-generated images.
- ▶ Verification is repeated, after the nose has been topically decongested, by correlating intranasal anatomic sites visualized endoscopically.

▶ 87

+61782 Stereotactic Computer-assisted (Navigational) procedure; cranial, extradural

- ▶ Throughout the procedure, the operative field is visualized endoscopically, with frequently confirmation of position and relationship to surrounding vital structures provided by placing a tracking device within the operative field, correlating the endoscopic view with the position indicated by the images on the computer monitor.
- ▶ Based on this information, intra-operative decisions are made to appropriately modify the approach and resection to help ensure a safe and effective surgical procedure.

▶ 88

Surgery/Digestive System/Tongue and Floor of Mouth/Excision

41112 Excision of lesion of tongue with closure; anterior two-thirds

41113 posterior one-third

41114 with local tongue flap

(List 41114 in addition to code 41112 or 41113)

▶(Do not report 41114 in conjunction with 41112, 41113)◀

▶ 89

Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency)

● 64611 Chemodenervation of parotid and submandibular salivary glands, bilateral

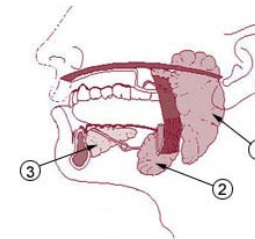
▶(Report 64611 with modifier 52 if fewer than four salivary glands are injected)◀

▶ 90

64611 Chemodenervation of parotid and submandibular salivary glands, bilateral

- ▶ Used typically for ptyalism (excess salivation) not controlled by other methods
- ▶ Lasts several months and requires re-injection
- ▶ Not to be confused with chemodenervation treatment of gustatory sweating (Frey's syndrome)
 - ▶ 64653 Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck) per day
- ▶ Different than destruction by neurolytic agent

▶ 91



Parotid & Submandibular Salivary Glands

▶ 92

69801 Labyrinthotomy – 2010 version

- 69801 Labyrinthotomy, with or without cryosurgery including other nonexcisional destructive procedures or perfusion of vestibuloactive drugs (single or multiple perfusions); transcanal
(69801 includes all required infusions performed on initial and subsequent days of treatment)
- 69802 with mastoidectomy

▶ 93

Revised Labyrinthotomy Codes/Deleted & Added Parenthetical Notes for 2011

- ▲ 69801 Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal
- ~~(69801 includes all required infusions performed on initial and subsequent days of treatment)~~
- ▶ (Do not report 69801 more than once per day) ◀
- ▶ (Do not report 69801 in conjunction with 69420, 69421, 69433, 69436 when performed on the same ear) ◀
- ▲ 69802 with mastoidectomy

▶ 94

Category III Automated Audiometry

- 0208T Pure tone audiometry (threshold), automated, air only
 - 0209T air and bone
 - 0210T Speech audiometry threshold, automated;
 - 0211T with speech recognition
 - 0212T Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combines), automated
- ▶ (For audiometry testing using audiometers performed manually by a qualified health care professional, see 92551-92557) ◀

▶ 95

Audiometry Codes Cross-Reference

- 92551 Screening test, pure tone, air only
- 92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
- (For hearing aid evaluation and selection, see 92590-92595)
- ▶ (For automated audiometry, see 0208T – 0212T) ◀

▶ 96

Vestibular Function Tests, with Recording (eg, ENG)

- 92540 Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with
- 92541 Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
- ▶ (Do not report 92541 in conjunction with 92540 or the set of 92542, 92544, and 92545) ◀
- 92542 Positional nystagmus test, minimum of 4 positions, with recording
- ▶ (Do not report 92542 in conjunction with 92540 or the set of 92541, 92544, and 92545) ◀

▶ 97

Vestibular Function Tests, with Recording (eg, ENG)

- 92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording
- ▶ (Do not report 92544 in conjunction with 92540 or the set of 92541, 92542, and 92545) ◀
- 92545 Oscillating tracking test, with recording
- ▶ (Do not report 92545 in conjunction with 92540 or the set of 92541, 92542, and 92544) ◀

▶ 98

Vestibular Function Tests, with Recording (eg, ENG)

- 92546 Sinusoidal vertical axis rotational testing
- +92547 Use of vertical electrodes (List separately in addition to code for primary procedure)
- ▶ (Use 92547 in conjunction with 92541-92540-92546) ◀

▶ 99



Pain Medicine

▶ 100

Transforaminal Epidural Injections

- ▶ Recognized to be dependent upon the use of imaging – either CT or, more commonly, fluoroscopy
- ▶ Although not yet a proven technique, a Category III code was created to allow for reporting of the use of ultrasound with these injections as the imaging technique

▶ 101

Changes in the Nervous System section

1. Revisions to the Paravertebral Spinal Nerves and Branches notes.
2. Revisions to codes 64479, 64480, 64483 and 64484 to include fluoroscopic and CT guidance with transforaminal epidural injection services;
3. Addition of several parenthetical notes following codes 64479, 64480, 64483 and 64484 to instruct appropriate use of these services.

▶ 102

Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic

- ▶ (Imaging guidance fluoroscopy or CT) and any injection of contrast are inclusive components of 64479-64484, Imaging guidance and localization are required for the performance of 64479 – 64484) ◀
- ▲ 64479 Injection(s) anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
- ▶ (For transforaminal epidural injection under ultrasound guidance, use 0228T) ◀

▶ 103

Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic

- + ▲ 64480 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
- ▶ (For transforaminal epidural injection under ultrasound guidance, use 0229T) ◀
- ▶ (For transforaminal epidural injection at the T12-L1 level, use 64479) ◀

▶ 104

Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic

▲ **64483** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

▶ (For transforaminal epidural injection under ultrasound guidance, use 0230T) ◀

▶ 105

Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic

+ ▲ **64484** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

▶ (For transforaminal epidural injection under ultrasound guidance, use 0231T) ◀

▶ (64479-64484 are unilateral procedures. For bilateral procedures, use modifier 50) ◀

▶ 106

Paravertebral Facet (Spinal) Joint and Medial Nerves Branches

New Guidelines

▶ (Imaging guidance [fluoroscopy CT] and any injection of contrast are inclusive components of 64490-64495. Imaging guidance and localization are required for the performance of paravertebral facet joint injections described by 64490-64495. If imaging is not used, report 20552-20553. If ultrasound guidance is used, report 0213T-0218T) ◀

▶ (For bilateral paravertebral facet injection procedure, use modifier 50) ◀

▶ (For paravertebral facet injection of the T12-L1 joint, or nerves innervating that joint, use 64490) ◀

▶ 107

Neurostimulators (Peripheral Nerve)

▶ (Do not report 64555 in conjunction with 64566) ◀

● **64566** Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming

▶ (Do not report 64566 in conjunction with 64555, 95970-95972) ◀

● **64568** Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator

▶ (Do not report 64568 in conjunction with 61885, 61886, 64570) ◀

▶ 108

Neurostimulators (Peripheral Nerve)

- 64569 Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator
 - ▶ (Do not report 64569 in conjunction with 64570 or 61888) ◀
 - ▶ (For replacement of pulse generator, use 61885) ◀
- 64570 Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
 - ▶ (Do not report 64570 in conjunction with 61888) ◀
 - ▶ (64573 has been deleted) ◀
- 64611 Chemodeneration of parotid and submandibular salivary glands, bilateral
 - ▶ (Report 64611 with modifier 52 if fewer than four salivary glands are injected) ◀

▶ 109

Neuroplasty (Exploration, Neurolysis or Nerve Decompression)

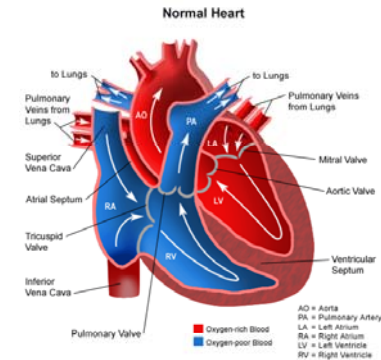
- ▶ Neuroplasty is the surgical decompression or freeing of intact nerve from scar tissue, including external neurolysis and/or transposition to repair or restore the nerve. ◀
- ▶ (For percutaneous neurolysis, see 62263, 62264, 62280-62282) ◀

▶ 110



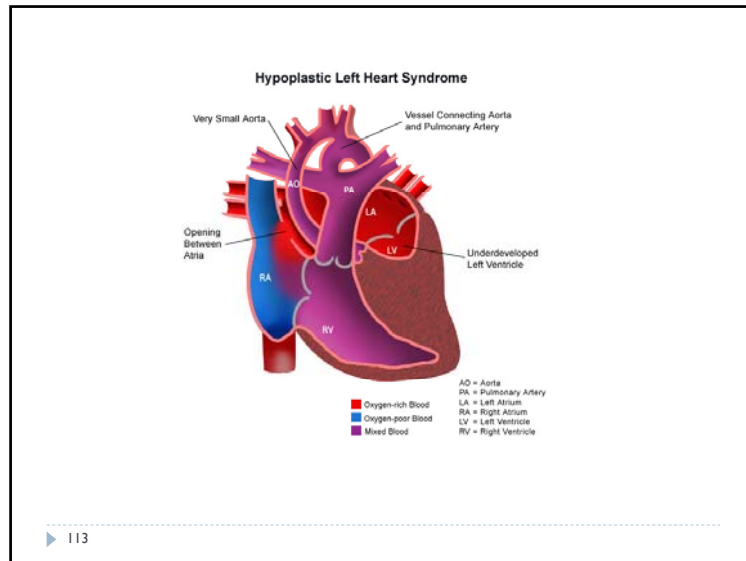
Cardiology/Cardiothoracic, and Vascular Surgery

▶ 111



Cardiothoracic/Vascular

▶ 112



Cardiac Hybrid Procedures – Stage 1

- 33620 Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)
 - ▶ (For banding of the main pulmonary artery related to septal defect, use 33960) ◀
- 33621 Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)
 - ▶ (For placement of stent, use 37207) ◀
 - ▶ (Report both 33620, 33621 if performed in same session) ◀

▶ 114

Cardiac Hybrid Procedures Stage II

- 33622 Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)
 - ▶ (Do not report 33622 in conjunction with 33619, 33767, 33822, 33840, 33845, 33851, 33853, 33917) ◀
 - ▶ (For bilateral, bidirectional Glenn procedure, use 33622 in conjunction with 33768) ◀

▶ 115

Hybrid Procedure for Hypoplastic Left Heart Syndrome

- ▶ Not to be confused with Hybrid Coronary Revascularization
 - ▶ Usually minimally invasive LIMA to LAD CABG
 - ▶ Staged or Concurrent Coronary Stenting

▶ 116

Cardiac Hybrid Procedures (cont'd)

Septal Defect

33690 Banding of pulmonary artery

- ▶ (For right and left pulmonary artery banding in a single ventricle [eg, hybrid approach stage I] use 33620) ◀

Shunting Procedures

+33768 Anastomosis, cavopulmonary, second superior vena cava (List separately in addition to primary procedure)

- ▶ (Use 33768 in conjunction with 33478, 33617, 33622, 33767) ◀

▶ 117

Thoracic Aortic Surgery Codes

Thoracic Aortic Aneurysm

▲ 33860 Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed

- ▶ (33861 has been deleted. To report use 33864) ◀

▲ 33863 Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)

- ▶ (Do not report 33863 in conjunction with 33405, 33406, 33410, 33411, 33412, 33413, 33860) ◀

▶ 118

Thoracic Aortic Surgery Codes

▲ 33864 Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)

- ▶ (Do not report 33864 in conjunction with 33400, 33860-33863) ◀

▶ 119

Cardiovascular System

Cardiac Valves

▲ 33411 Replacement, aortic valve; with aortic annulus enlargement, noncoronary ~~esp~~ sinus

▶ 120

Ascending Aorta Repair

Surgery – Cardiovascular System
Heart and Pericardium – Thoracic Aortic Aneurysm

▲ 33860 Ascending aorta graft, with cardiopulmonary bypass, includes with or without valve suspension, when performed;

▶ (33861 has been deleted. To report, use 33864) ◀

▶ 121

Ascending Aorta Repair (cont'd)

▲ 33863 Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using composite prosthesis valved conduit and coronary reconstruction (eg, Bentall)

▶ (Do not report 33863 in conjunction with 33405, 33406, 33410, 33411, 33412, 33413, 33860) ◀

▶ 122

Ascending Aorta Repair (cont'd)

▲ 33864 Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic annulus root remodeling (eg, David Procedure, Yacoub Procedure)

▶ (Do not report 33864 in conjunction with 32551, 33210, 33211, 33400, 33860-33863) ◀

▶ 123

Cardiology Code Changes for 2011

Grouped the family of codes into three families:

1. Holter monitoring codes for recording up to 48 hours (93224-93227)
2. Mobile cardiovascular telemetry codes (93228-93229)
3. Event monitoring codes (93268-93272)

The word "Wearable" has been deleted.

Now we have the word "External" ...

▶ (93230-93237 have been deleted. To report **external** electrocardiographic rhythm derived monitoring for up to 48 hours, see 93224-93227) ◀

▶ 124

External Cardiovascular Device Monitoring

- ▶ Telephonic transmission codes 93012 and 93014 have been deleted.
- ▶ Telephonic transmission services are now reported with codes 93268-93272, which have been revised to include remote download up to 30 days.
- ▶ The term “wearable” is deleted and replaced with “External”.

▶ 125

New Cardiac Catheterization Language

- ▶ Key elements
 - ▶ Most non-congenital procedures will now be reported with one code
 - ▶ Separate codes are retained for congenital heart catheterization

▶ 126

Other Key Elements

- ▶ For non-congenital studies, the catheterization codes include most injection procedure services, imaging supervision, interpretation, and report
- ▶ For congenital studies, injection procedures are reported separately and include imaging supervision, interpretation, and report
- ▶ For all of the cardiac catheterization procedures, imaging supervision, interpretation, and report is included with the injection procedure and not reported separately
- ▶ *For left heart catheterization, left ventriculography (injection procedure, supervision, interpretation, and report) is included when performed

▶ 127

Cardiac Catheterization

⊙ 93505 Endomyocardial biopsy

▶ (93501, 93508 - 93529 have been deleted. To report, see 93451 - 93461) ◀

⊙ 93530 Right heart catheterization, for congenital cardiac anomalies

Current codes for cardiac catheterization of congenital heart patients (93530-93533) remain active.

▶ 128

New Cardiac Catheterization Codes

- ⊙● 93451 Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed
- ▶ (Do not report 93451 in conjunction with 93453, 93456, 93457, 93460, 93461) ◀
- ⊙● 93452 Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
- ⊙● 93453 Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
- ▶ (Do not report 93453 in conjunction with 93451, 93452, 93456-93461) ◀

▶ 129

Cardiac Catheterization

- ▶ 93451-93461 includes all roadmapping angiography in order to place the catheters, including any injections and imaging supervision, interpretation and report. It does not include contrast injection(s) and imaging supervision, interpretation, and report for imaging that is separately identified by specific procedure code(s). For right ventricular or right atrial angiography performed in conjunction with cardiac catheterization for congenital or noncongenital heart disease, use 93566. For aortography, use 93567. For pulmonary angiography, use 93568. For angiography of non-coronary arteries and veins, performed as a distinct service, use appropriate codes from the Radiology section and the Vascular Injection Procedures section.

▶ 130

New Cardiac Catheterization Codes

- ⊙● 93454 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation
- ⊙● 93455 with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts)
- ⊙● 93456 with right heart catheterization
- ⊙● 93457 with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization

▶ 131

New Cardiac Catheterization Codes

- ⊙● 93458 with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
- ⊙● 93459 with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
- ⊙● 93460 with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography

▶ 132

New Cardiac Catheterization Codes

- ◎● 93461 with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
- ◎+● 93462 Left heart catheterization by transeptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)
- ▶ (Use 93462 in conjunction with 93452, 93453, 93458 - 93461, 93651, 93652) ◀

▶ 133

New Cardiac Catheterization Codes

- ◎+● 93463 Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent), including assessing hemodynamic measurements before, during, after, and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)
- ▶ (Use 93463 in conjunction with 93451-93453, 93456-93461, 93530-93533) ◀
- ▶ (Report 93463 only once per catheterization procedure) ◀
- ▶ (Do not report 93463 for pharmacologic agent administration in conjunction with coronary interventional procedure codes 92975, 92977, 92980, 92982, 92995) ◀

▶ 134

New Cardiac Catheterization Codes

- ◎+● 93464 Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)
- ▶ (Use 93464 in conjunction with 93451-93453, 93456-93461, 93530-93533) ◀
- ▶ (Report 93464 only once per catheterization procedure) ◀
- ▶ (For pharmacologic agent administration, use 93463) ◀

▶ 135

Deletion of prior injection codes, imaging, supervision and report codes

- ▶ (93539-93545 have been deleted. To report, see 93451-93461, 93563-93568) ◀
- ▶ (93555, 93556 have been deleted. See introductory guidelines for Cardiac Catheterization and Injection Procedures) ◀

▶ 136

New codes for congenital heart catheterization

- ⊙+●93563 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)
- ⊙+●93564 for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)

▶ 137

Additional new injection, imaging supervision, interpretation and report codes

- ⊙+●93565 for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)
 - ▶ (Do not report 93565-93565 in conjunction with 93452-93461) ◀
 - ▶ (Use 93563-93565 in conjunction with 93530-93533) ◀
- ⊙+●93566 for selective right ventricular or right atrial angiography
 - ▶ (List separately in addition to code for primary procedure) ◀

▶ 138

Additional new injection, imaging supervision, interpretation and report codes

- ⊙+●93567 for supraaortic aortography (List separately in addition to code for primary procedure)
- ⊙+●93568 for pulmonary angiography (List separately in addition to code for primary procedure)
- ▶ (Use 93566-93568 in conjunction with 93530-93533, 93451-93461) ◀

▶ 139

WARNING! Dyslexic coding may be hazardous to your (coding) integrity!

- ▶ Old Code:
 - 93541 Injection procedure during cardiac catheterization; for pulmonary angiography
- ▶ New Code:
 - 93451 Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed

▶ 140

Left heart catheterization, coronary angiography, left ventriculography

Currently – 5 codes	2011 – One code
93510 (LHC)	● 93458
93543 (LV injection)	
93545 (coronary injection)	
93555 (LV S+I)	
93556 (coronary S + I)	

<http://www.scai.org/default.aspx>

▶ 141

Cardiac catheterization parenteticals

- ▶ Additional first order or higher catheterization in vascular families supplied by a first order vessel different from a previously selected and coded family should be separately coded using the conventions described above.
- ▶ (For injection procedures in conjunction with cardiac catheterization, see 93452-93461, 93563-63568) ◀

▶ 142

Cardiac Catheterization Parenteticals

36215 Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family

- ▶ (For catheter placement for coronary angiography, use 93508, 93454-93964) ◀

+36218 additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)

▶ 143

Cardiac Catheterization Parenteticals

- ▶ (When coronary artery, arterial conduit (eg, internal mammary, inferior epigastric or free radical artery) or venous bypass graft angiography is performed in conjunction with cardiac catheterization, see the appropriate cardiac catheterization, injection procedure and imaging supervision code(s) (93501-93556, 93451-93461, 93503-93533, 93563-93568) in the **Medicine section** of the CPT codebook. When coronary artery, arterial coronary conduit or venous bypass graft angiography is performed without concomitant left heart cardiac catheterization, use 93508, 93454-93457, 93563, 93564. When internal mammary artery angiography only is performed without a concomitant left heart cardiac catheterization, use 36216 or 36217 as appropriate.) ◀

▶ 144

Cardiac Catheterization Parentheticals

Diagnostic Radiology – Vascular Procedures

Arteries and Veins

75600 Aortography, thoracic, without serialography, radiological supervision and interpretation

▶ (For injection procedure, use ~~93544~~, 93567, which includes imaging supervision, interpretation, and report) ◀

75605 Aortography, thoracic, by serialography, radiological supervision and interpretation

▶ (For injection procedure, use ~~93544~~, 93567, which includes imaging supervision, interpretation, and report) ◀

▶ 145

Cardiac Catheterization Parentheticals

75625 Aortography, abdominal, by serialography, radiological supervision and interpretation

▶ (For injection procedure, use ~~93544~~ 93567, which includes imaging supervision, interpretation, and report) ◀

75741 Angiography, pulmonary, unilateral, selective, radiological supervision and interpretation

▶ (For injection procedure, use ~~93544~~–93568, which includes imaging supervision, interpretation, and report) ◀

75743 Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation

▶ (For injection procedure, use ~~93544~~–93568, which includes imaging supervision, interpretation, and report) ◀

▶ 146

Cardiac Catheterization Parentheticals

75746 Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation

▶ (For injection procedure, use ~~93544~~–93568, which includes imaging supervision, interpretation, and report) ◀

▶ (For introduction of catheter; injection procedure, see ~~93501–93533, 93539, 93540, 93545, 93556–93451, 93453 – 93461, 93530 – 93533, 93563, 93564, 93568~~) ◀

75756 Angiography, internal mammary, radiological supervision and interpretation

▶ (For introduction of catheter; injection procedure, see ~~93501–93533, 93545, 93556–93451–93462, 93530–93533, 93563, 93564, 93567, 93568~~, which includes imaging supervision, interpretation and report) ◀

▶ 147

Cardiac Catheterization Parentheticals

+75774 Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)

▶ (For introduction of catheter; injection procedure, see ~~93501–93533, 93545, 93555, 93556–93451 – 93462, 93530–93533, 93563–93568~~) ◀

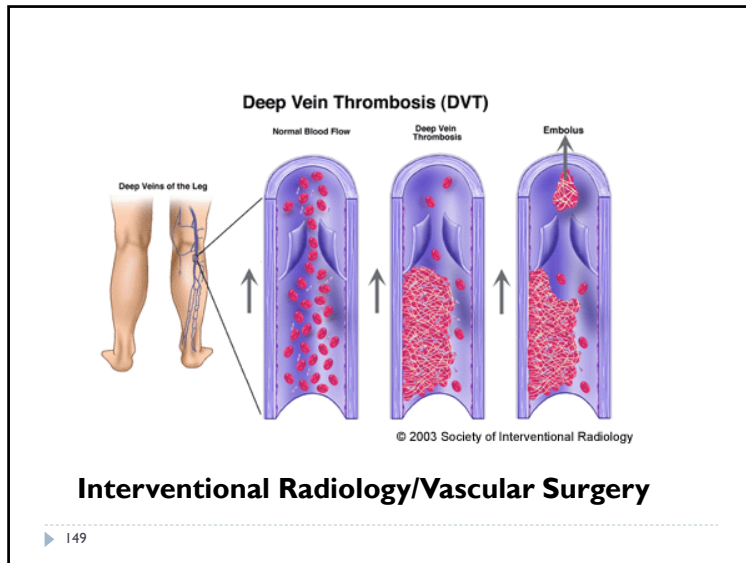
HEART

▶ (For cardiac catheterization procedures, see ~~93501–93556~~ 93451–93570) ◀

▶ (75552–75556 have been deleted. To report, see 75557, 75559, 75561, 75563, 75565) ◀

75557 Cardiac magnetic resonance imaging for morphology and function without contrast material;

▶ 148



Endovascular Revascularization Procedures

Percutaneous vascular intervention procedures are currently reported with the component coding approach.

At least three codes are used to report each treatment at any single level in the arterial tree.

- ❖ Selective catheterization code
- ❖ Radiological supervision and interpretation codes
- ❖ Treatment code

The new structure bundles these three services into one code.

▶ 150

Primary Codes				
	PTA	Stent	Atherectomy	Atherectomy Stent
Iliac	37220	37221		
Femoral/Popliteal	37224	37226	37225	37227
Tibial/Peroneal	37228	37230	37229	37231
Add-On Codes				
	PTA	Stent	Atherectomy	Atherectomy Stent
Iliac	37222	37223		
Tibial/Peroneal	37232	37234	37234	37235

▶ 151

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Endovascular Revascularization Procedures

- ▶ Codes 37220 – 37235
- ▶ Used to describe lower extremity endovascular revascularization services performed for occlusive disease.
- ▶ Built on progressive hierarchies with more intensive services inclusive of lesser intensive services.
- ▶ Inclusive of all of the services provided for that vessel should be reported (ie, use the code inclusive of the most intensive services provided).
- ▶ **Only one code from this family should be reported for each lower extremity vessel treated.**

▶ 152

Endovascular Revascularization Procedures

- ▶ Codes 37220 – 37235
- ▶ Endovascular procedures performed percutaneously and/or through an open surgical exposure
- ▶ Balloon angioplasty (eg, low-profile, cutting balloon, cryoplasty)
- ▶ Stenting (eg, balloon-expandable, self-expanding bare metal, covered, drug-eluting)
- ▶ Atherectomy (eg, directional, rotational, laser)

Each code in this family includes any balloon angioplasty, when performed.

▶ 153

Endovascular Revascularization Procedures

Codes 37220 – 37235

Includes the work of:

- ❖ Accessing and selectively catheterizing the vessel
- ❖ Traversing the lesion
- ❖ Embolic protection if used
- ❖ Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- ❖ Closure of the arteriotomy by any method
- ❖ Radiological supervision and interpretation directly related to the intervention(s) performed

▶ 154

Recent Diagnostic Study Definition

- ▶ Option #1
- ▶ Diagnostic angiography performed at the time of an interventional procedure is separately reportable if:
 - * No prior catheter-based angiographic study is available
 - * A full diagnostic study is performed
 - * The decision to intervene is based on this study

▶ 155

Recent Diagnostic Study Definition

- ▶ Option #2
- ▶ A prior study is available, but:
 - * The patient's condition with respect to the clinical indication has changed since the prior study, OR
 - * There is inadequate visualization of the anatomy and/or pathology, OR
 - * There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

▶ 156

Diagnostic Angiography at the Time of an Interventional Procedure

- ▶ New introductory wording has been added:
- ▶ “If diagnostic angiography is necessary, is performed at the same session as the interventional procedure and meets the above criteria, modifier 59 must be appended to the diagnostic radiological supervision and interpretation code(s) to denote that diagnostic work has been done following these guidelines.”

▶ 157

LE Endovascular Intervention

- ▶ Four Interventional Groupings
 1. Percutaneous transluminal angioplasty (PTA)
 2. Stent (with or without PTA)
 3. Atherectomy (with or without PTA)
 4. Stent & atherectomy (with or without PTA)
- ▶ NOTE:
 - * For the same vessel, only one code chosen
 - * No more “intent rule” for failure of PTA

▶ 158

Definition in Introductory Wording

- ▶ PTA includes:
 - * Low-profile, cutting balloon, cryoplasty
- ▶ Atherectomy includes:
 - * Directional, rotational laser
- ▶ Stenting includes:
 - * Balloon-expandable, self-expanding, bare metal, covered, drug-eluting

▶ 159

LE Endovascular Intervention Territory Rules

- ▶ Report the most comprehensive treatment within a given vessel
- ▶ Hierarchy differs from the numeric order:
 - * Stent and atherectomy
 - * Atherectomy
 - * Stent
 - * PTA

↓ Decreasing intensive service
- ▶ Femoropopliteal is always one vessel
- ▶ Iliac and Tibial/peroneal → max of 3 vessels

▶ 160

LE Endovascular Intervention Territory Rules

- ▶ Only one base code allowed in each territory
 - * In the femoral /popliteal territory, all branches are included in the primary code
 - * Additional ipsilateral vessels treated in the iliac and tibial /peroneal territories requires the use of add-on code(s)
- ▶ Base code repeated when bilateral using -59
- ▶ One lesion that spans two vessels is treated as one vessel (e.g., lesion expanding from distal CIA to proximal EIA treated w/ I stent.

▶ 161

LE Endovascular Intervention

- ▶ What remains separately reportable?
 - * Mechanical thrombectomy
 - * Thrombolytic infusion
 - * Ultrasound guidance for vascular access
 - * Additional catheter access solely for diagnostic imaging purposes

▶ 162

ILIAC

Therapy	Base Code	Add-on Code
PTA	37220	+37222
Atherectomy with or without PTA	N/A	N/A
Stent with or without PTA	37221	+37223
Stent & atherectomy with or without PTA	N/A	N/A

▶ 163

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FEMOROPOPLITEAL

Therapy	Base Code	Add-on Code
PTA	37224	N/A
Atherectomy with or without PTA	37225	N/A
Stent with or without PTA	37226	N/A
Stent & atherectomy with or without PTA	37227	N/A

▶ 164

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TIBIAL / PERONEAL		
Therapy	Base Code	Add-on Code
PTA	37228	+37232
Atherectomy with or without PTA	37229	+37233
Stent with or without PTA	37230	+37234
Stent & atherectomy with or without PTA	37231	+37235

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Example #1

- ▶ 65 year old male with a left foot non-healing ulcer has a palpable femoral pulse and no pedal pulse
 - ▶ Prior angiography reveals a left SFA moderate stenosis & AK popliteal occlusion
 - ▶ Right CFA retrograde access is obtained and the left SFA popliteal artery is selected
 - ▶ The SFA disease is treated with PTA and the popliteal occlusion is treated initially with PTA and then intravascular stent given significant recoil
- ▶ 166

Example #1

- ▶ Left popliteal stent 37226
- ▶ Left SFA PTA & popliteal PTA N/A
- ▶ Third order catheterization N/A
- ▶ Completion angiography N/A

Remember that multiple therapies in one vessel is reported using the most intensive service for that vascular territory – simultaneous use of 37224 is not appropriate

▶ 167

Example #2

- ▶ 65 year old diabetic female with forefoot gangrene has three vessel tibial artery occlusion by angiography
 - ▶ Antegrade femoral access is obtained
 - ▶ The PT, AT, and peroneal arteries are all selectively catheterized
 - ▶ The TP trunk, PT, AT, and peroneal arteries are all approached with atherectomy
 - ▶ After completion, PTA is used to treat diffuse residual stenosis in each of the four vessels
- ▶ 168

Example #2

- ▶ AT artery atherectomy 37229
- ▶ PT artery atherectomy 37233
- ▶ Peroneal artery atherectomy 37233, 59
- ▶ TP trunk atherectomy N/A
- ▶ Tibial PTA x 4 N/A
- ▶ Selective tibial catheterization N/A

TP trunk atherectomy is bundled into the peroneal or posterior tibial artery intervention and selective catheterization is additionally bundled

▶ 169

Example #3

- ▶ Rare instance with separate catheter
- ▶ 70 year old with claudication has no femoral pulses and inflow disease by non-invasive arterial imaging. No other imaging is performed
- ▶ Left brachial arterial access is obtained and a non-selective aortic catheterization is performed with diagnostic aortography
- ▶ Bilateral femoral punctures are performed with deployment of kissing common iliac artery stents

▶ 170

Example #3

- ▶ Rare Instance with separate catheter

Right CIA stent	37221
Left CIA stent	37221, 59
Arm non-selective catheter	36200, 59
Aortogram	75625, 26, 59

The femoral artery based catheters are bundled

▶ 171

Non-invasive Physiologic Arterial Evaluation Vascular Lab Changes for 2011

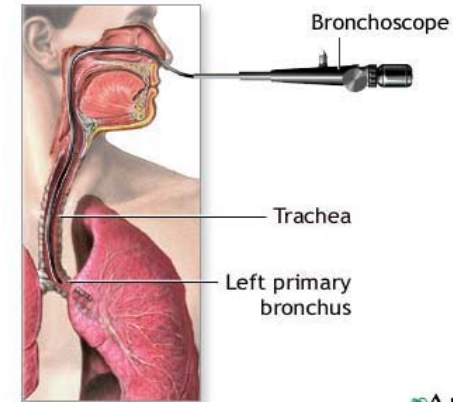
- ▶ CPT code 93922 flagged for excessive growth
- ▶ Concern that Ankle Brachial index (ABI) being used inappropriately
- ▶ Redefined the minimum service required to report each of the three codes
- ▶ Additional language in the introductory wording for vascular laboratory on ABI

▶ 172

Summary of Changes: 93924

- ▶ Bidirectional Doppler waveform OR volume plethysmography
- ▶ Measurements at rest AND at time intervals
- ▶ Standardized protocol on a motorized treadmill plus recording of:
 - * Time of onset of claudication
 - * Maximal walking time
 - * Time to recover in both legs
- ▶ Treadmill specific – no alternative exercises OK

▶ 173



Pulmonary / Sleep Medicine

▶ 174

Surgery/Respiratory System Trachea and Bronchi

- ◎31622 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)
- ◎●31634 with balloon occlusion; with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed
- ◎31635 with removal of foreign body

▶ (For removal of implanted bronchial valves, see (0251T, 0252T) ◀

▶ 175

New 2011 Photodynamic Therapy Time-Reporting Parentheticals

- +96570 Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)
 - ▶ (Report 96570 with modifier 52 for service of less than 23 minutes with report) ◀

▶ 176

New 2011 Photodynamic Therapy Time-Reporting Parentheticals

+ 96571 each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)

▶ (For 23-37 minutes of service, use 96570. For 38-52 minutes of service, use 96570 in conjunction with 96571) ◀

(96570, 96571 are to be used in addition to bronchoscopy, endoscopy codes)

▶ 177

Evolution of Home Sleep Study Codes

	2008 – 2009	2010	2011
Type II	G0398	95806	95806
Type III	G0399	0203T	95800
Type IV	G0400	0204T	95801

▶ 178

New Unattended Sleep Testing Codes

95806 Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)

▶ (Do not report 95806 in conjunction with 93041 – 93227, 93228, 93229, 93268 – 93272, 95800, 95801) ◀

#●95800 Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time

▶ (Do not report 95800 in conjunction with 93041 – 93227, 93228, 93229, 93268 – 93272, 93803, 95806, 95801) ◀

▶ 179

New Unattended Sleep Testing Codes

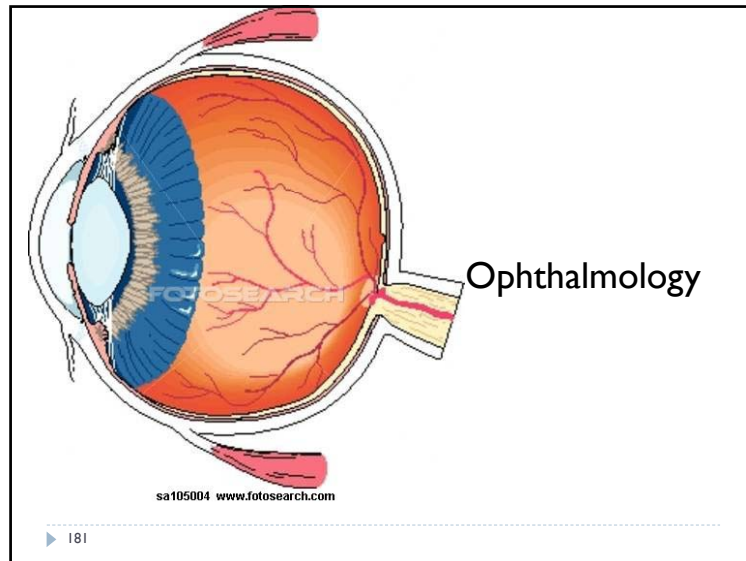
#●95801 Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)

▶ (Do not report 95801 in conjunction with 93041 – 93227, 93228, 92339, 93268 – 93272, 95806, 95800) ◀

▶ (For unattended sleep study that measures heart rate, oxygen saturation, respiratory analysis and sleep time, use 95800) ◀

▶ (For unattended sleep study that measures **a minimum** of heart rate, oxygen saturation, and respiratory analysis, use 95801) ◀

▶ 180



Transluminal dilation

- 66174 Transluminal dilation of aqueous outflow canal; without retention of device or stent
- 66175 with retention of device or stent

▶ 182

Amniotic Membrane

- 65778 Placement of amniotic membrane on the ocular surface for wound healing; self-retaining
- 65779 single layer, sutured
- ▲ 65780 Ocular surface reconstruction; amniotic membrane transplantation; multiple layers
- ▶ (Do not report 65778, 65779 in conjunction with 65430, 65435, 65780) ◀
- ▶ (For placement of amniotic membrane using tissue glue, use 66999) ◀

▶ 183

SCODI (2010)

- 92135 Scanning laser ophthalmic diagnostic imaging, positioned, (eg, scanning laser) with intraocular support, unilateral

▶ 184

SCODI (2011)

- 92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
- 92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
- 92134 retina
- ▶ (Do not report 92133 or 92134 at the same patient encounter) ◀
- ▶ (For scanning computerized ophthalmic diagnostic imaging of the optic nerve and retina, see 92133, 92134) ◀

▶ 185

Iridotomy / Irdectomy

- 66761 Iridotomy / iridectomy by laser surgery (eg, for glaucoma) (per session)

2010 stated, "one or more sessions"

▶ 186

New Code Categories

Glaucoma

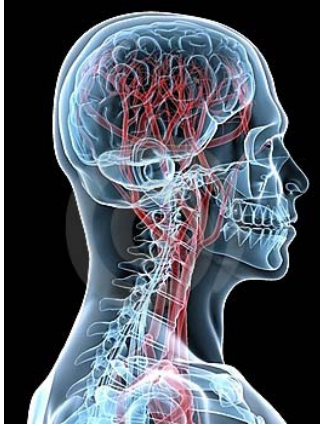
- ▶ 2 New codes to represent canaloplasty
- 66174 Transluminal dilation of aqueous outflow canal; without retention of device or stent
- 66175 with retention of device or stent

▶ 187

New Codes for Diabetic Retinopathy

- 92227 Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
- 92228 Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral

▶ 188



Neurology

▶ 189

Neurosurgery – Computerized Surgical Navigation

- ▶ Old Code = + 61795 Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal (List separately in addition to code for primary procedure)
- ▶ Originally only for intracranial procedures
- ▶ ENT and spine uses

▶ 190

New Codes – Computerized Surgical Navigation

- + ● 61781 Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)
 - ▶ (Do not report 61781 in conjunction with 61720–61791, 61796–61799, 61863–61868, 62201, 77371–77373, 77432) ◀
- + ● 61782 Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)
 - ▶ (Do not report 61781, 61782 by the same provider during the same surgical session) ◀

▶ 191

New Codes – Computerized Surgical Navigation

- + ● 61783 Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)
 - ▶ (Do not report 61783 in conjunction with 63620, 63621) ◀

▶ 192

Neurosurgery
Anterior Cervical Discectomy & Fusion

▶ Old:

- 63075 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace
- 22554-51 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

▶ 193

Neurosurgery
Anterior Cervical Discectomy & Fusion

▶ New:

- 22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2
- + ● 22552 cervical below C2, each additional interspace (List separately in addition to code for separate procedure)

▶ 194

Neurosurgery
Anterior Cervical Discectomy & Fusion

- 63075 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace
- ▶ (Do not report 63075 in conjunction with 22554, even if performed by separate providers. To report anterior cervical discectomy and interbody fusion at the same level during the same session, use 22551) ◀

▶ 195

Neurosurgery
Anterior Cervical Discectomy & Fusion

- +63076 cervical, each additional interspace (List separately in addition to code for primary procedure)
- ▶ (Do not report 63076 in conjunction with 22554, even if performed by separate providers. To report anterior cervical discectomy and interbody fusion at the same level during the same session, use 22552) ◀

▶ 196

Muscle and Range of Motion Testing

- ▶ **95857** ~~Tensilon~~ Cholinesterase inhibitor challenge test for myasthenia gravis

▶ 197

Intraoperative Neurophysiology

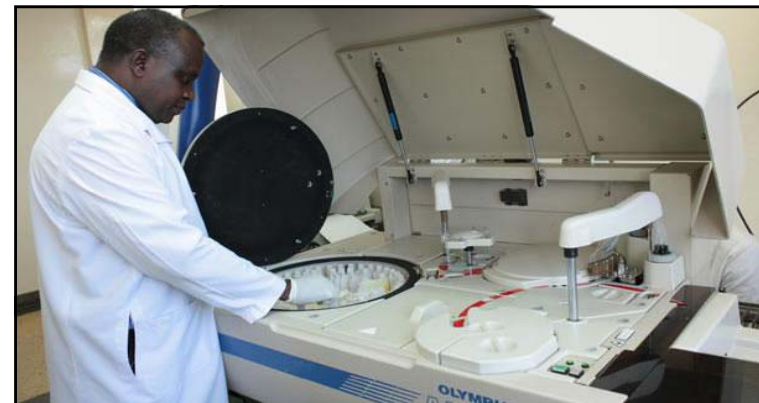
- +95920 Intraoperative neurophysiology testing, per hour (List separately in addition to code for primary procedure)
- ▶ For procedures that last beyond midnight, report services using the day on which the monitoring began and using the total hours monitored.
- ▶ (For time spent waiting on standby before monitoring, use 99360.)◀

▶ 198

Special EEG Tests

- ▶ Codes 95950-95953 and 95956 are used per 24 hours of recording.
- ▶ For recording more than 12 hours, do not use modifier 52.
- ▶ For recording 12 hours or less, use modifier 52.
- ▶ Codes 95951 and 95956 are used for recordings in which interpretations can be made throughout the recording time, with interventions to alter or end the recording or to alter the patient care during the recordings as needed.

▶ 199



Pathology/Laboratory

▶ 200

Pathology and Laboratory/Drug Testing

● 80104 Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure

▶ (For qualitative analysis by multiplexed screening kit for multiple drugs or drug classes, use 80104) ◀

▶ 201

Chemistry

▶ ~~82926~~ Gastric acid, free and total, each specimen

▶ ~~82928~~ Gastric acid, free or total, each specimen

▶ (82926, 82928 have been deleted) ◀

▶ (For gastric acid analysis, use 82930) ◀

● 82930 Gastric acid analysis, includes pH if performed, each specimen

▶ 202

Chemistry

82951 Glucose; tolerance test (GTT), 3 specimens (includes glucose)

+ ▲ 82952 tolerance test, each additional beyond 3 specimens (List separately in addition to code for primary procedure)

▶ (Use 82952 in conjunction with 82951) ◀

▶ 203

Chemistry

● 83861 Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity

▶ (For microfluidic tear osmolarity of both eyes, report 83861 twice) ◀

▶ 204

Chemistry

- 84112 Placental alpha microglobulin-I (PAMG-I), cervicovaginal secretion, qualitative

(A qualitative test for the detection of amniotic fluid in vaginal secretions, using immunochromatography to detect human PAMG-I protein present in amniotic fluid of pregnant women. Placental Microglobulin is a marker of fetal membrane rupture due to its high level in the amniotic fluid, low level in blood, and extremely low background level in cervico-vaginal secretions when the fetal membranes are intact.)

▶ 205

Hematology and Coagulation

- ▲ 85597 Platelet Phospholipid neutralization; platelet
- 85598 hexagonal phospholipid

▶ 206

Immunology

- ▲ 86480 Tuberculosis test, cell mediated immunity antigen response measurement; of gamma interferon ~~antigen response~~
- 86481 enumeration of gamma interferon-producing T-cells in cell suspension

▶ 207

Transfusion Medicine

- 86902 Blood typing; antigen testing of donor blood using reagent serum, each antigen test
- ~~86903 Blood typing; antigen screening for compatible blood unit using reagent serum, per unit screened~~
- ▶ (If multiple blood units are tested for the same antigen, 86902 should be reported once for each antigen for each unit tested). ◀
- 86965 Pooling of platelets or other blood products
- ▶ (For injection(s) of platelet rich plasma, use 0232T) ◀

▶ 208

Microbiology

- 87501 Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, reverse transcription and amplified probe technique, each type or sub-type
- 87502 influenza virus, for multiple types or sub-types, reverse transcription and amplified probe technique, first 2 types or sub-types
- + ● 87503 influenza virus, for multiple types or sub-types, multiplex reverse transcription and amplified probe technique, each additional influenza virus type or subtype **beyond 2**

▶ (Use 87503 in conjunction with 87502) ◀

▶ 209

Microbiology

- ▲ 87901 Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, reverse transcriptase and protease regions
- # ● 87906 HIV-1, other region (eg, integrase, fusion)

▶ 210

Cytopathology

- 88120 Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual
 - 88121 using computer-assisted technology
- ▶ (For morphometric in situ hybridization on cytologic specimens other than urinary tract, see 88367, 88368) ◀
- ▶ (For more than 5 probes, use 88399) ◀

▶ 211

Cytopathology

- ▲ 88172 Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s) for diagnosis, first evaluation episode, each site

▶ (The evaluation episode represents a complete set of cytologic material submitted for evaluation and is independent of the number of needle passes or slides prepared. A separate evaluation episode occurs if the proceduralist provider obtains additional material from the same site, based on the prior immediate adequacy assessment, or a separate lesion is aspirated) ◀

▶ 212

Cytopathology

- ▶ (Report one unit of 88173 for the interpretation and report from each anatomic site, regardless of the number of passes or evaluation episodes performed during the aspiration procedure) ◀

▶ 213

Cytopathology

- # ● 88177 Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)
- ▶ (When repeat immediate evaluation episode(s) is required on subsequent cytologic material from the same site, eg, following determination the prior sampling that was not adequate for diagnosis, use 1 unit of 88177 for each additional evaluation episode) ◀

▶ 214

Surgical Pathology

- + ▲ 88332 Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)
- ▶ (Use 88332 in conjunction with 88331) ◀
- + ▲ 88334 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure)
- ▶ (Use 88334 in conjunction with 88331, 88333) ◀

▶ 215

Surgical Pathology

- 88363 Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)

▶ 216

In Vivo (eg, Transcutaneous Laboratory Procedures)

- **88749** Unlisted in vivo (eg, transcutaneous) laboratory service

- ▶ (For all in vivo measurements not specifically listed, use 88749) ◀
- ▶ (For wavelength fluorescent spectroscopy of advanced glycation end products (skin), use 023T) ◀

▶ 217

Deleted Codes

- ~~89130~~ Gastric intubation and aspiration, diagnostic, each specimen, for chemical analyses or cytopathology;
- ~~89132~~ after stimulation
- ~~89135~~ 1 hour
- ~~89136~~ two hours
- ~~89140~~ two hours including gastric stimulation (eg, histalog, pentagastrin)
- ~~89141~~ three hours, including gastric stimulation

- ▶ Codes 89130-89141 have been deleted.
- ▶ To report, see 43754, 43755

▶ 218

Deleted Codes

- ~~89100~~ Duodenal intubation and aspiration; single specimen (eg, simple bile study or afferent loop culture) plus appropriate test procedure
- ~~89105~~ collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube

(To report, see 43756, 43757)

- ~~89225~~ Starch granules, feces
- ~~89235~~ Water load test

▶ 219



Radiology

▶ 220

Abdominal & Pelvic CT

- ▶ CT imaging of the abdomen and pelvis is frequently performed during the same setting
- ▶ New combined CPT codes are intended to reflect current practice

▶ 221

Abdominal CT

- 74150 Computed tomography, abdomen; without contrast material
- 74160 with contrast material(s)
- 74170 without contrast material, followed by contrast material(s) and further sections
- ▶ (For a combined CT abdomen and pelvis study, see 74176 – 74178) ◀

▶ 222

Pelvic CT

- 72192 Computed tomography, pelvis; without contrast material
- 72193 with contrast material(s)
- 72194 without contrast material, followed by contrast material(s) and further sections
- ▶ (For a combined CT abdomen and pelvis study, see 74176 – 74178) ◀

▶ 223

Combined Codes

- 74176 Computed tomography, abdomen and pelvis; without contrast material
- 74177 with contrast material(s)
- 74178 without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions
- ▶ (Do not report 74176 – 74178 in conjunction with 72192 – 72194, 74150 – 74170) ◀
- ▶ (Report 74176, 74177, or 74178 only once per CT abdomen and pelvis examination) ◀

Do Not Unbundle!

▶ 224

Important New Instructions

- ▶ Do not report more than one CT of the abdomen or CT of the pelvis for any session.
- ▶ For combinations of CT of the abdomen with CT of the pelvis performed at the same session, use the following tables.

▶ 225

CT Abdomen & Pelvis Grid

Stand Alone Code	74150 – CT Abdomen WO Contrast	74160 – CT Abdomen W/Contrast	74170 – CT Abdomen WO/W Contrast
72192 – CT Pelvis WO Contrast	74176	74178	74178
72193 – CT Pelvis with Contrast	74178	74177	74178
72194 – CT Pelvis WO/W Contrast	74178	74178	74178

▶ 226

New Extremity Ultrasound Codes

- **76881** Ultrasound, extremity, nonvascular, real-time with image documentation; complete
 - **76882** limited, anatomic specific
- ▶ A complete ultrasound examination of an extremity (76881) consists of real time scans of a specific joint that includes examination of the:
- *Muscles,
 - *Tendons,
 - *Joint ,
 - *Other soft tissue structures **AND**
 - *Any identifiable abnormality.

▶ 227

New Instructions: Limited

- ▶ Code 76882 refers to an examination of an extremity that would be performed primarily for evaluation of muscles, tendons, joints, and/or soft tissues.
- ▶ This is a limited examination of the extremity where a specific anatomic structure such as a tendon or muscle is assessed.
- ▶ In addition, the code would be used to evaluate a soft-tissue mass that may be present in an extremity where knowledge of its cystic or solid characteristics is needed.

▶ 228

Other Clarification

- ▶ For spectral and color Doppler evaluation of the extremities, use 93925, 93926, 93930, 93931, 93970, or 93971 as appropriate.
- ▶ (76880 has been deleted. To report ultrasound examination of an extremity, see 76881, 76882) ◀

▶ 229

Interventional Radiology

- ▶ Component coding
 - Surgical component codes
 - Guidance and/or radiological supervision and interpretation codes
 - Example: Paracentesis
 - *49080: needle/catheter placement
 - *76942: ultrasound guidance

▶ 230

Peripheral Vascular “Package” Codes

- ▶ In short, in most circumstances in which a lower extremity peripheral arterial intervention (e.g., angioplasty, stent) is performed, that service is now reported with a single bundled code
 - ❖ Code includes access, selective catheterization, angiographic guidance, and all interventions within a vessel or family
 - ❖ Old component codes are no longer appropriate

▶ 231

Transcatheter Procedures

- ▲ 75962 Transluminal balloon angioplasty, peripheral artery other than cervical carotid, renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation
 - ▶ (For radiological supervision and interpretation for transluminal angioplasty in iliac, femoral, popliteal, and tibial/peroneal arteries, see 37220–37235) ◀
- + ▲ 75964 Transluminal balloon angioplasty, each additional peripheral artery other than cervical carotid, renal or other visceral artery, iliac and lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)

▶ 232

Transluminal Atherectomy

- ▶ (75992 has been deleted. To report see 37225, 37227, 37229, 37231, 0238T)
- ▶ (75993 has been deleted. To report, see 37233, 37235, 0238T)
- ▶ (75994 has been deleted. To report, use 0234T)
- ▶ (75995 has been deleted. To report, use 0235T)
- ▶ (75996 has been deleted. To report, use 0235T)

▶ 233

Percutaneous Cholecystostomy

- ▶ Previously component coded
47490 for surgical component and
Usually:
76942 for US guidance, or
77012 for CT guidance

▶ 234

Percutaneous Cholecystostomy

- ▲ 47490 Percutaneous, c-Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation
- ▶ (Do not report 47490 in conjunction with 74505, 74305, 75989, 76942, 77002, 77012, 77021) ◀
- ▲ 47480 Cholecystotomy or cholecystostomy, open with exploration, drainage, or removal of calculus (separate procedure)
- ▶ (For percutaneous cholecystostomy, use 47490) ◀

▶ 235

Ultrasound Guidance Procedures

- 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation
- ▶ (Do not report 76942 in conjunction with 37760, 37761, 43232, 43237, 43237, 43242, 45341, 45342, or 64479–64484, 64490–64495, 76975, 0228T–0231T, 0232T, 0249T) ◀

▶ 236

Fluoroscopic Guidance

▶ (Do not report guidance codes 77001, 77002, 77003 for services in which fluoroscopic guidance is included in the descriptor) ◀

▲ 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

(For paravertebral facet joint injection, see 64490–64495. For transforaminal epidural needle placement and injection, see 64479–64484)

▶ (Do not report 77003 in conjunction with 64479 – 64484, 64490 – 64495) ◀

▶ 237

Deleted Codes

~~76150 Xeroradiography~~

~~76350 Subtraction in conjunction with contrast studies~~

▶ 238



Questions?

Thank you!

▶ 239

References

- ▶ <http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=14032>
- ▶ <http://www.cms.gov/transmittals/downloads/R815OTN.pdf>
- ▶ <http://www.cms.gov/Transmittals/downloads/R2109CP.pdf>
- ▶ <http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf>
- ▶ CPT and RBRVS 2011 Annual Symposium, Chicago, Illinois, November 10-12, 2010

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