CPT® Changes 2013 Workshops

An insider’s view of the 2013 CPT code updates
CPT® Changes 2013
Workshops

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Welcome!

• Session time: 8:00am-5:00pm
  – Morning and afternoon break
  – Lunch will be provided
• CEUs
• Resources provided!
  – 2013 CPT Changes Handout
  – 2013 CPT Professional
  – 2013 CPT Changes: An Insider’s View

• Discounts for other available resources!
Objectives

• AMA – CPT® Editorial Board
• Relative Value Utilization Committee (RUC)
• RBRVS and CMS Updates – interspersed throughout
• 2013 CPT® Updates
  – Changes
  – Revisions
  – Deletions
• Examples and rationales throughout!
Identification of strengths

- Atmosphere of continuous improvement
- Fair process
- Inclusive open meetings

Identification of weaknesses with mandates to:

- Create and update internal structure and function definitions (ie, workgroups, Health Care Professionals Advisory Committee (HCPAC))
- Define emerging or undefined process steps (ie, appeals)
- Identify new uses of the public CPT web site as vehicle for communication
How Do We Benefit From This Effort?
http://www.ama-assn.org/go/cpt

• Transparency evident on Web site by increasingly available information
  – Coding
  – Meetings
  – Application
  – Structure and Function of CPT Editorial Panel committees

Coding Information

• Historic Web Information
  – Category II, Category III, and vaccine codes published to CPT web site

• Free New Information
  – Molecular Pathology Codes (Tier 1, Tier 2, MAAA) - Tier 1/Tier 2 code descriptors published to website before publication to code set to get public comment
  – Preventive Services Coding
New Codes – on the AMA website

- Category II
  http://www.ama-assn.org/go/cpt-cat2

- Category III
  http://www.ama-assn.org/go/cpt-cat3

- Vaccine Codes
  http://www.ama-assn.org/go/cpt-vaccine
Other AMA Coding Information

CPT Code Set Errata

http://www.ama-assn.org/go/cpt-errata
- Real Time Updates of Current CPT Files
  - Updates based on
    - Staff review
    - Panel review and actions
    - Specialty Society Review
    - Comments received from all stakeholders
- Other Errata:
  - CPT Changes
  - CPT Assistant
  - ACC/AMA Coding guide
Application Information-How a Code Becomes a Code

http://www.ama-assn.org/go/cpt-process

• Overview and history of CPT, the process of code request submission and review, and the roles that the Panel and Advisory Committee groups have in the process.
How To Stay Current With All of This Information!

Email Notifications
Sign up to receive email notification when changes are posted to the AMA website
– CPT Announcements (Workgroup Notifications)
– Category II codes, Category III codes, Vaccine codes
– Errata
– Panel Agenda Proposals
– Summary of Actions.
– Registration for CPT Editorial Panel meetings

AMA/Specialty Society RVS Update Committee (RUC)
Overview

• The RUC Process
• Process to Improve Valuation within RBRVS
• Chronic Care Coordination Workgroup (C3W)

The RUC Process

• RUC Composition
  – American Medical Association
  – CPT Editorial Panel
  – American Osteopathic Association
  – Practice Expense Review Committee
  – Health Care Professionals Advisory Committee

<table>
<thead>
<tr>
<th>Anesthesiology</th>
<th>Internal Medicine</th>
<th>Plastic Surgery</th>
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<tbody>
<tr>
<td>Cardiology</td>
<td>Neurology</td>
<td>Primary Care*</td>
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<tr>
<td>Dermatology</td>
<td>Neurosurgery</td>
<td>Psychiatry</td>
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<tr>
<td>Emergency Medicine</td>
<td>Obstetrics/Gynecology</td>
<td>Radiology</td>
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<tr>
<td>Family Medicine</td>
<td>Ophthalmology</td>
<td>Rheumatology*</td>
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<tr>
<td>General Surgery</td>
<td>Orthopaedic Surgery</td>
<td>Thoracic Surgery</td>
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<tr>
<td>Geriatric Medicine</td>
<td>Otolaryngology</td>
<td>Urology</td>
</tr>
<tr>
<td>Infectious Disease*</td>
<td>Pathology</td>
<td>Vascular Surgery*</td>
</tr>
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<td></td>
<td>Pediatrics</td>
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</tbody>
</table>

* indicates rotating seat
The RUC Process

• RUC Advisory Committee – One physician representative and one staff appointment from each of the 122 specialty societies in the AMA House of Delegates
• Health Care Professionals Advisory Committee – Allows for participation by non-MD/DO health professionals who are required to use CPT and RBRVS

The RUC Process
Health Care Professionals Advisory Committee
11 Organizations Represent:

• Physician Assistants
• Chiropractors
• Nurses
• Occupational Therapists
• Optometrists
• Physical Therapists
• Podiatrists
• Psychologists
• Audiologists
• Speech Pathologists
• Social Workers
• Dieticians
The RUC Process

• Physician Work
  – Time it takes to perform procedure
  – Intensity of service as compared to other physician services
  – RUC has been developing recommendations since 1992; utilizing same methodology as Hsaio/Harvard
  – Data collected by national medical specialty societies

The RUC Process

• Direct Practice Expense Inputs (PE)
  – Clinical Staff (Type and Time)
  – Medical Supplies (Type and Quantity)
  – Medical Equipment (Type and Minutes in Use)
  – Standard rules developed
  – Specialty experts quantify in great detail
  – The RUC does not determine pricing information (CMS via contractors)
The RUC Process

- Professional Liability Insurance (PLI)
  - CMS updates each five years – next update in 2015
  - Collects national premium data for $1 million/$3 million claims-made-policies
  - Risk factors are developed for each specialty and costs allocated to individual codes using work RVU and specialty mix
  - RUC comments on methodology and provides information on an annual basis regarding expected specialty mix for new CPT codes

The RUC Process – Annual Cycle

CPT Editorial Panel ➔ Level of Interest ➔ Survey ➔ Specialty RVS Committee ➔ The RUC

Medicare Payment Schedule ➔ CMS ➔ The RUC
Process to Improve Valuation Within RBRVS

• In 2006, and in response to inadequate identification of overvalued services in the previous Five-Year Review of the RBRVS processes (1995, 2000 and 2005), the RUC decided to objectively identify potentially misvalued codes within the RBRVS

• Similar timing to initial MedPAC discussions regarding relativity within the RBRVS

Process to Improve Valuation Within RBRVS

• Objective Screens Developed by the RUC’s Relativity Assessment Workgroup:
  – New Technology
  – Site of Service Anomalies
  – High Volume Growth
  – High Intra-service Work Per Unit of Time (IWPUT)
  – Services Surveyed by One Specialty – Now Performed by A Different Specialty
  – Harvard Valued (Utilization over 30,000)
  – Bundled CPT Services (75% or More)
Process to Improve Valuation Within RBRVS

• Screens Developed by CMS:
  – CMS Fastest Growing
  – Low Value/Billed in Multiple Units
  – Low Value/High Volume Codes
  – Multi-Specialty Points of Comparison List
  – CMS High Expenditure Procedural Codes
  – Harvard-Valued Medicare Allowed Charges > $10 million
  – PE Stand Alone Procedure Time

• Total Number of Codes Identified: 1,462

• Codes Completed 1,155
  – Work and PE Maintained 375
  – Work Increased 102
  – Work Decreased 370
  – PE Inputs Reduced 118
  – Deleted from CPT 190

• Codes Under Review 307
  – Referred to CPT 72
  – 2013/2014 Review 235
Process to Improve Valuation Within RBRVS

• In 2008, a joint CPT/RUC Workgroup identified 23 code groups reported together more than 95% of the time (Utilizing 2005 Medicare Claims Data)
  • All of these code pairs have been addressed and now bundled within CPT.
  • To date, the Workgroup has identified an additional 50 code groups reported together more than 75% of the time (Utilizing 2008 and 2009 Medicare Claims Data)
  • Anticipated completion of 20 code groups bundled coding proposals by CPT 2014
  • Remaining 30 code group bundled coding proposals by CPT 2016

Example – Bundling of CT of the Pelvis and Abdomen, Responding to GAO and others who perceive duplication in resource inputs

• Approximately $400 million was redistributed to the 2011 Medicare conversion factor (0.5% increase) to account for the efforts on the work relative values.
• This lead to $40 million redistribution within the PLI RVUs and combined with other recommendations, $570 million redistribution within the practice expense RVUs, for a total overall redistribution of **$1 billion** in 2011.
• In 2009 and 2010 minor increases to the conversion factor for work modifications and redistribution within the PLI and PE RVUs also occurred.
• The RUC’s efforts for 2009-2012 resulted in **$2.5 billion** in redistribution within the MFS.
Chronic Care Coordination Workgroup (C3W)

- The charge to the C3W was to provide strategic direction to CPT and RUC to address the adequacy of coding and valuation of care coordination services and prevention/management of chronic disease.
- A request to CMS to immediately implement payment for anticoagulant management, telephone calls, team conferences and patient education was submitted to CMS on October 3, 2011. CMS declined to implement this recommendation.

Chronic Care Coordination Workgroup (C3W)

- In Fall 2011, the C3W recommended that codes for transitional care management and complex chronic care coordination be developed for CPT 2013.
- CPT Editorial Panel completed this work in May 2012.
- The RUC submitted recommendations to CMS (October 10, 2012) for consideration in the November 1, 2012 Final Rule.

CMS accepted the CPT Transitional Care Management codes and RUC recommendations.

- CMS is considering adoption of the complex care coordination codes developed by the AMA as the Agency continues to explore payment for primary care services in future rulemaking.

For 2013, CMS considered the complex chronic care coordination codes as bundled and not separately reportable for Medicare.
Physician Fee Schedule Update!

• Medicare payment rates will be reduced by 26.5 percent for services in 2013 unless Congress passes a law to avert these cuts prior to January 1, 2013.

• The President’s budget calls for averting these cuts and finding a permanent solution to this problem.
CY 2013 Final Rule with Comment Period

- Released for Display November 1, 2012
- Will be Published November 16, 2012
- Comment Deadline December 31, 2013
- Generally, effective January 1, 2013
- Available at:
  www.ofr.gov/OFRUpload/OFRData/2012-26900_PI.pdf

Physician Fee Schedule Update

TABLE 87: CALCULATION OF THE CY 2013 PFS CF

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversion Factor in effect in CY 2012</td>
<td></td>
<td>$34.0376</td>
</tr>
<tr>
<td>CY 2012 Conversion Factor had statutory increases not applied</td>
<td></td>
<td>$24.6712</td>
</tr>
<tr>
<td>CY 2013 Medicare Economic Index</td>
<td>0.8 percent (1.008)</td>
<td></td>
</tr>
<tr>
<td>CY 2013 Update Adjustment Factor</td>
<td>0.6 percent (1.006)</td>
<td></td>
</tr>
<tr>
<td>CY 2013 RVU Budget Neutrality Adjustment</td>
<td>-0.1 percent (0.99932)</td>
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<tr>
<td>CY 2013 Conversion Factor</td>
<td></td>
<td>$25.0008</td>
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<tr>
<td>Percent Change from Conversion Factor in effect in CY 2012 to CY 2013 Conversion Factor</td>
<td>-26.5%</td>
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<table>
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<tr>
<th>Description</th>
<th>Value</th>
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<tr>
<td>CY 2013 Anesthesia Conversion Factor</td>
<td>$15.93</td>
</tr>
<tr>
<td>Percent Change from 2012 to 2013</td>
<td>-26.0%</td>
</tr>
</tbody>
</table>
Geographic Practice Cost Indices (GPCIs)

Statutory Authority: The SSA requires CMS to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three fee schedule components:

- Physician work;
- Practice expense; and
- Malpractice expense.

Relative Cost Difference: The PE and malpractice GPCIs reflect the full relative cost differences, while the law requires that the physician work GPCIs reflect only one-quarter of the relative cost differences compared to the national average.

CY 2013 Impacts* (Resulting From Expiration of 1.0 Work GPCI Floor)

Localities Receiving a Decrease their geographic adjustment factor (GAF)

- 53 out of the 89 PFS localities

Top Decreases: Localities with a GAF decreasing by more than 2 percent include:

- Puerto Rico;
- Montana;
- South Dakota;
- Oklahoma;
- Rural Missouri; and
- Iowa.

Bundling Report to Congress
Due January 1, 2013

Required by Middle Class Tax Relief and Jobs Creation Act of 2012

• “...conduct a study that examines options for bundled or episode-based payments to cover physicians’ services currently paid under the physician fee schedule. ...for one or more prevalent chronic conditions (such as cancer, diabetes, and congestive heart failure) or episodes of care for one or more major procedures (such as medical device implantation).”

• In conducting the study, we are to consult with medical professional societies and other relevant stakeholders.

• Report is to include recommendations on suitable alternative payment options and associated implementation requirements (such as timelines, operational issues, and interactions with other payment reform initiatives).

Multiple Procedure Payment Reduction (MPPR)

Medicare has a longstanding policy to reduce payment by 50 percent for the second and subsequent procedures furnished to the same patient by the same physician on the same day, largely based on the efficiencies in the practice expense and pre- and post-surgical physician work.

• Surgical Procedures
• TC component of advanced imaging services (CT, MRI & Ultrasound)
• PE component of therapy services
• PC of advanced imaging services
Multiple Procedure Payment Reduction (MPPR)

CY 2013

- PC & TC of advanced imaging services if furnished by physicians in the same group practice, same patient, same session, same day.
- TC for cardiovascular diagnostic tests (25%) same patient, same physician (or physicians in same group practice), same day
- TC for diagnostic ophthalmology tests (20%) same patient, same physician (or physicians in same group practice), same day.

CPT® Introduction
CPT® Nomenclature Reporting Neutrality

The CPT Editorial Panel is required to adhere to the policy of neutrality with respect to identifying who may perform a procedure or service that is described in the CPT® code set. Therefore, the CPT code set avoids statements about who is or is not qualified to perform the services and procedures described in the CPT code set, other than to state that he or she must be qualified.

-CPT Panel-

CPT® Nomenclature Neutrality

(Qualified Health Care Professional (QHP) Terminology Revisions)

The CPT code set is a work of medical nomenclature consisting of a set of codes, descriptions and guidelines that describes procedures and services performed by physicians and other qualified health care professionals. Any procedure or service in any section of the CPT code set may be used to designate the services rendered by any qualified physician or other qualified health care professional or entity (eg, hospital, clinical laboratory, home health agency). To provide consistency with this statement, the following is a list of those CPT codes, guidelines, and/or parenthetical instructions where terminology has been revised with the intent of provider neutrality in the CPT code set.
Background

- CPT is an “equal opportunity” reporting system
- CPT is not the “turf police”

Instructions for Use of the CPT Codebook – Reminder!

A “physician or other qualified healthcare professional” is an individual who is qualified by education, training, licensure /regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from “clinical staff.” A clinical staff member is a person who works under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services.
Instructions for Use of the CPT Codebook

Throughout CPT code set the use of terms such as “physician,” “qualified health care professional,” or “individual” is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency).

Note: Throughout the session today you will see reference to “QHP” being used for “qualified Health care professional.” This is for abbreviated purposes only and is not reflected in CPT.

Place of Service and Facility Reporting

The paragraph on the previous slide is included in the Place of Service and Facility Reporting paragraph in addition to the following change:

…the CPT code set uses the term facility to describe such circumstances providers and the term nonfacility to describe services settings, or circumstances in which no facility reporting may occur. Services provided in the home by an agency are facility services. Services provided in the home by a physician or qualified health care professional who is not a representative of the agency are nonfacility services.
Time

The CPT code set contains many codes with a time basis for code selection. The following standards shall apply to time measurement, unless there are code or code-range–specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary. Time is the face-to-face time with the patient. Phrases such as “interpretation and report” in the code descriptor are not intended to indicate in all cases that report writing is part of the reported time. A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used. See also the Evaluation and management (E/M) Services Guidelines.

Time

When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service. Some services measured in units other than days extend across calendar dates. When this occurs, a continuous service does not reset and create a first hour. However, any disruption in the service does create a new initial service. For example, if intravenous hydration (96360, 96361) is given from 11 PM to 2 AM, 96360 would be reported once and 96361 twice. For facility reporting on a single date of service or for continuous services that last beyond midnight (ie, over a range of dates), report the total units of time provided continuously.
Time

However, if instead of a continuous infusion, a medication was given by intravenous push at 10 PM and 2 AM, as the service was not continuous, both administrations would be reported as initial (96374) and sequential (96376) as: 1) no other infusion services were performed; and 2) the push of the same drug was performed more than 30 minutes beyond the initial administration. For facility reporting per single calendar date, both administrations would be reported as initial (96374). For continuous services that last beyond midnight, use the date in which the service began and report the total units of time provided continuously.

CPT Reminders!

- Indicates that a new procedure number was added to the CPT nomenclature
- Indicates a code revision has resulted in a substantially altered procedure descriptor
- Indicates a CPT add-on code
- Indicates a code that is exempt from the use of modifier 51 but is not designated as a CPT add-on procedure/service
- Indicates revised guidelines, cross-references, and/or explanatory text
- Indicates a code that typically includes moderate sedation
- Indicates a code for a vaccine that is pending FDA approval
- Indicates a resequenced code
- Indicates a reinstated or recycled code
Evaluation and Management Services

New an Established Patient

Revision

► …In the instance where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient’s encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician. ◄
Evaluation and Management

• Deletion in numerous sections regarding the use of the term “physician” to avoid restriction of who may use a particular CPT code

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient’s status (ie, changes in history, physical condition and response to management) since the last assessment by the physician.

99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

Evaluation and Management

• Addition of “or other qualified health care professional” throughout the E/M guidelines and respective sections, include;
  - Introduction -Time
  - New and Established Patient - Concurrent Care and Transfer of Care
  - Emergency Services -Newborn Care
  - Critical Care -Nursing Home
  - Team Conferences -Care Plan Oversight
Evaluation and Management

The following refinements to the “counseling and coordination of care” and “typical time” language are also applicable to the E/M codes listed below.

Counseling and Coordination of Care/Typical Time Revisions
99201-99205, 99212-99215,
99218-99220, 99224-99226,
99221-99223, 99231-99236,
99241-99245, 99251-99255,
99281-99285, 99304-99306,
99307-99310, 99318, 99324-99328,
99334-99337, 99341-99345,
99347-99350

Evaluation and Management

Due to the number and length of these refinements, only the 99203 revision has been included to illustrate the revised text.

(See CPT 2013 for further information).

▲99203  Office or other outpatient visit.

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

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes are spent face-to-face with the patient and/or family.
Observation or Inpatient Care Services (Including Admission and Discharge Services)

- Typical times have been added to codes 99234-99236.

- RUC surveys were used to obtain the data of typical times used to perform these services.

Observation or Inpatient Care Services (Including Admission and Discharge Services) (99234-99236)

Revisions were made to each of these codes to include typical times.

99234 …Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient’s hospital floor or unit.
Observation or Inpatient Care Services (Including Admission and Discharge Services) (99234-99236)

Revisions were made to each of these codes to include typical times.

99235 …Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient’s hospital floor or unit.

99236 …Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient’s hospital floor or unit.
Evaluation and Management (E/M) Nursing Facility Services guidelines

Physicians and other qualified health care professionals have a central role in assuring that all residents receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the residents’ physical and psychosocial functioning.…

Exception to provider neutrality

Should have retained “physician” and not include QHP 2013 Errata

Initial Nursing Facility Care New or Established Patient guidelines

Removed “physician”

When the patient is admitted to the nursing facility in the course of an encounter in another site of service (e.g., hospital emergency department, physician’s office), all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial nursing facility care when performed on the same date as the admission or readmission.

Retained “physician”

The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the nursing facility setting.

Hospital discharge or observation discharge…
99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components:
Subsequent Nursing Facility Care guidelines

All levels of subsequent nursing facility care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient’s status (i.e., changes in history, physical condition, and response to management) since the last assessment by the physician or other qualified health care professional.

99307  Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

Edits emphasize provider neutrality

Evaluation and Management (E/M) Services

Codes which have been revised to include both emphasis on CPT neutrality and exception to CPT neutrality:

99310  99337  99350
Subsequent Nursing Facility Care guidelines

Edits emphasize CPT neutrality

Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:
- A comprehensive interval history;
- A comprehensive examination;
- Medical decision making of high complexity.

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

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

Exception to CPT neutrality

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

Retain the term "physician"

Nursing Facility Discharge Services guidelines

The nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician or other qualified health care professional for the final nursing facility discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent by the physician on that date...

99315  Nursing facility discharge day management; 30 minutes or less

Edits emphasize provider neutrality
Pediatric Critical Care Patient Transport

Two codes 99485 and 99486 have been established to report non-face-to-face physician supervision of interfacility pediatric critical care transport, 24 months of age or younger.

# 99485 Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes
Pediatric Critical Care Patient Transport

#+● 99486 each additional 30 minutes (List separately in addition to code for primary procedure)
► (Use 99486 in conjunction with 99485)

Tip:
• CMS indicated that this service is bundled and not separately payable under Medicare

Work RVU: 99485 = 1.50; 99486 = 1.30

Pediatric Critical Care Patient Transport

► (For physician direction of emergency medical systems supervision for a pediatric patient older than 24 months of age, or at any age if not critically ill or injured, use 99288)
► (Do not report 99485, 99486 with any other services reported by the control physician for the same period)
► (Do not report 99485, 99486 in conjunction with 99466, 99467 when performed by the same physician)
Inpatient Neonatal and Pediatric Critical Care

Guideline revisions only including:

- Codes 99471-99476 are used for a critically ill infant or young child from 29 days of postnatal age through **less than 6 years of age**.
- Services for critically ill or critically injured child **6 years of age or older** would be reported with critical care codes 99291, 99292.

Inpatient Neonatal and Pediatric Critical Care

- Revisions to guidelines to clarify reporting of services when a neonate or infant becomes critically ill and the patient is transferred to a critical care level of care provided by a different individual in a different group.
- The reporting for the **transferring** and **receiving** individual is as follows:
Inpatient Neonatal and Pediatric Critical Care

• The **transferring** individual reports **one** of the following depending on the service performed:
  
  • Time-based Critical Care (99291, 99292)
  • Intensive care services (99477-99480)
  • Hospital care services (99221-99233)
  • Normal newborn service (99460, 99461, 99462)

Inpatient Neonatal and Pediatric Critical Care

• The **receiving** individual reports initial or subsequent inpatient neonatal or pediatric care 99468-99476, as appropriate based upon the patient’s age and whether this is the first or subsequent admission to the critical care unit for the hospital stay.
Inpatient Neonatal and Pediatric Critical Care

Further guideline revisions for the same patient on the same day:

Time based critical care services (99291, 99292) are not reportable by the same or different individual within the same group when neonatal or pediatric critical care services 99468-99476 are reported.

Initial and Continuing Intensive Care Services

• Guideline revisions only including:

Codes 99464 or 99465 may be reported in addition to the initial hospital care code 99477 when the physician or other qualified health care professional is present for the delivery (99464) or resuscitation (99465) is required.
Initial and Continuing Intensive Care Services

• Revisions to guidelines to clarify reporting of services when a neonate or infant becomes critically ill on a day when initial or subsequent intensive care services (99477-99480) have been reported by one individual and the patient is transferred to a critical care level of care provided by a different individual from a different group, as follows:

Initial and Continuing Intensive Care Services

• The **transferring** individual reports **one** of the following depending on the service performed:
  • Time-based Critical Care (99291, 99292)
  • Intensive care services (99477-99480)
Initial and Continuing Intensive Care Services

- The *receiving* individual reports initial or subsequent inpatient neonatal or pediatric care 99468-99476 based upon the patient’s age and whether this is the first or subsequent admission to critical care for the same hospital stay.

Initial and Continuing Intensive Care Services

- Further guideline revisions clarify reporting of services when a neonate or infant becomes critically ill on a day when 99477-99480 have been performed by the *same* individual or group:
  - Report only initial or subsequent inpatient neonatal or pediatric critical care 99468-99476 depending on the patient’s age and first or subsequent admission to critical care for the same hospital stay.
Chronic Care Coordination Workgroup

- The charge to the Chronic Care Coordination Workgroup (C3W) was to provide strategic direction to CPT and RUC to address the adequacy of coding and valuation of care coordination services and prevention/management of chronic disease.
- A request to CMS to immediately implement payment for anticoagulant management, telephone calls, team conferences and patient education was submitted to CMS on October 3, 2011.
- CMS declined to implement this recommendation.

Chronic Care Coordination Workgroup

- In Fall 2011, the C3W recommended that codes for transitional care management and complex chronic care management be developed for CPT 2013.
- CPT Editorial Panel completed this work in May 2012.
- The RUC submitted recommendations to CMS, October 10, 2012, for consideration in the November 1, 2012 Final Rule.
Chronic Care Coordination Workgroup

The C3W recommendations/minutes are at www.ama-assn.org/go/carecoordination

Complex Chronic Care Coordination Services (CCCC)

Complex Chronic Care Coordination Services are:

- Patient centered management and support services provided by physicians, other qualified health care professionals (QHP), and clinical staff.
- Provided to an individual residing in a home or in a domiciliary, rest home, or assisted living facility.
- A care plan directed by a physician or QHP and typically implemented by clinical staff.
- Services that address the coordination of care by multiple disciplines and community service agencies.
Complex Chronic Care Coordination Services (CCCC)

• The reporting individual provides or oversees the management and/or coordination of services, as needed, for:
  – All medical conditions
  – Psychosocial needs
  – Activities of daily living

• Patients requiring CCCC may be identified by:
  – Algorithms that utilize reported conditions and services (eg, predictive modeling risk score or repeat admissions or emergency department use)
  OR
  – Clinical judgment
Complex Chronic Care Coordination Services (CCCC)

• CCCC Patients:
  – Typically have 1 or more chronic continuous or episodic health conditions
  – Commonly require the coordination of a number of specialties and services.
  – May have medical and psychiatric behavioral co-morbidities complicating their care.
  – May have social support weaknesses or access to care difficulties.

Complex Chronic Care Coordination Services (CCCC)

• Codes: 99487-99489
  – Are reported once per calendar month
  – Include all non-face-to-face CCCC services
  – Include none or 1 face-to-face office or other outpatient, home, or domiciliary visit
  – May only be reported by the single physician or other QHP who assumes the care coordination role with a particular patient for the calendar month.
Complex Chronic Care Coordination Services (CCCC)

- **99487** Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

- **99488** first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month

- **99489** each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
Complex Chronic Care Coordination Services (CCCC)

• Two coding Tips have been added to further instruct on the use of these codes.

• Unlike other coding tips throughout the CPT code set, these coding tips are not found in the guidelines.

Coding Tip

Time of care coordination with the emergency department is reportable using 99487-99489, but time while the patient is inpatient or admitted as observation is not.
Coding Tip

If the physician personally performs the clinical staff activities, his or her time may be counted toward the required clinical staff time to meet the elements of the code.

Complex Chronic Care Coordination Services (CCCC)

- **What if additional E/M services are provided during the month?**
  Additional E/M services beyond the first visit may be reported separately by the same physician or other QHP during the same calendar month.

- **What if care coordination resumes after a discharge during a new month?**
  If care coordination resumes during a new month, start a new period or report transitional care management services (99495, 99496) as appropriate.
Complex Chronic Care Coordination Services (CCCC)

• The reporting individual provides or oversees the management and/or coordination of services, as needed, by providing first contact and continuous access for:
  – All medical conditions
  – Psychosocial needs
  – Activities of daily living

Complex Chronic Care Coordination Services (CCCC)

• CMS currently considering the CCCC services as **bundled** services.
  – Bundled into the services to which they are incident to and are not separately payable.
• CMS will consider payment of the complex care coordination codes developed by the AMA in future rulemaking.
• RUC recommendations are published as requested so others (health plans) could report while CMS considers
  – 99487 RUC recommended work RVU = 1.00
  – 99488 RUC recommended work RVU = 2.50
  – 99489 RUC recommended work RVU = 0.50
Transitional Care Management Services (TCM)

The transition in care is from:
- an inpatient hospital setting
- partial hospital
- observation status in a hospital
- skilled nursing facility/nursing facility

To the patient’s community setting:
- home
- domiciliary
- rest home
- or assisted living

Transitional Care Management Services (TCM)

- CPT TCM are services for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care.
- TCM services address any needed coordination of care performed by multiple disciplines and community service agencies.
Transitional Care Management Services (TCM)

- Codes 99495, 99496 require:
  - A face-to-face visit within the specified time frames
  - Interactive contact with the patient or caregiver within 2 business days of discharge and may be direct (face-to-face), telephonic, or by electronic means.
  - Medication reconciliation and management no later than the date of the face-to-face visit

- Codes 99495, 99496:
  - Are reported once per patient within 30 days of discharge
  - Are selected based on medical decision making and the date of the first face-to-face visit
  - May only be reported by one individual
Transitional Care Management Services (TCM)

- **99495 Transitional Care Management Services** with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least moderate complexity during the service period
  - Face-to-face visit, within 14 calendar days of discharge

  Work RVU = 2.11 and 40 minutes intra-service time

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Transitional Care Management Services

- **99496 Transitional Care Management Services** with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of high complexity during the service period
  - Face-to-face visit, within 7 calendar days of discharge

  Work RVU = 3.05
  - Adjusted the intra-service time from RUC recommended 60 minutes to **50 minutes**
  - Adjusted the clinical labor time in the direct practice expense inputs from 60 minutes to **70 minutes**.
Transitional Care Management Services

• CMS accepted the CPT TCM codes and RUC work RVU recommendations instead of the proposed G code for post-discharge transitional care management.

• CMS Modifications:

  - CMS indicated they will modify the prefatory instructions to allow physicians to bill these codes for new patients, not only established patients as specified in CPT.

  - CMS clarifies post-discharge service period in prefatory language
    – The physician who reports a global procedure should not be permitted to also report the TCM service.
    – “The same individual should not report transitional care management services provided in the post-operative period for a service with a global period.”
Transitional Care Management Services

• **CMS Modifications:**
  • CMS indicated the same physician may bill the discharge day management code for this patient and the TCM code for this patient
    – CMS is concerned about overlap and will monitor
  
  CMS Modifications:
  • CMS indicated that the same physician cannot bill the discharge day management code and the TCM included E/M visit on the same day.
    – The E/M visit is included in the TCM code, one assumes CMS will monitor when the E/M visit occurred via auditing documentation
  • CMS states “We wish to avoid any implication that the E/M services furnished on the day of discharge as part of the discharge day management service could be considered to meet the requirement for the TCM service that the physician or nonphysician practitioner must conduct an E/M service within 7 or 14 days of discharge.”
Transitional Care Management Services

Similar to the CCCC codes:

• Two coding Tips have been added to further instruct on the use of these codes.

• Unlike other coding tips throughout the CPT code set, these coding tips are not found in the guidelines.

Transitional Care Management Services

Coding Tip

If another individual provides TCM services within the postoperative period of a surgical package, modifier 54 is not required.
Transitional Care Management Services

Coding Tip

The required contact with the patient or caregiver, as appropriate, may be by the physician or qualified health care professional or clinical staff. Within two business days of discharge is Monday through Friday except holidays without respect to normal practice hours or date of notification of discharge. The contact must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care. If two or more separate attempts are made in a timely manner, but are unsuccessful and other transitional care management criteria are met, the service may be reported.

CCC and TCM

• An exclusionary parenthetical note follows the CCC and TCM codes precluding their use with several codes in both the E/M and Medicine sections.

• These excluded codes are also listed in the guidelines for CCC and TCM.
CCCC and TCM

For example:

**99366 Medical team conference** with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional

► (Do not report 99366 during the same month with 99487-99489)

► (Do not report 99366 when performed during the service time of codes 99495 or 99496)

• The CCCC and TCM codes include:
  – Care Plan Oversight Services
  – Prolonged Services Without Direct Patient Contact
  – Anticoagulant Management
  – Medical Team Conferences
  – Education and Training
The CCCC and TCM codes include:
  - Telephone Services
  - End Stage Renal Disease Services
  - On-Line Medical Evaluation
  - Preparation of Special Reports
  - Analysis of Data
  - Medication Therapy Management
  - TCM (when reporting CCCC)
  - CCCC (when reporting TCM)

Parenthetical notes have been added following many of these E/M and Medicine section codes excluding the CCCC and TCM codes from being reported in conjunction with these services.
## Transitional Care Management (TCM)

<table>
<thead>
<tr>
<th>Code (s)</th>
<th>Proposed Rule</th>
<th>CPT TCM Codes</th>
<th>Medicare CY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>GXXX1—Post-discharge transitional care management (medical decision making of moderate to high complexity)</td>
<td>99495—Transitional care management services (medical decision making of moderate complexity) 99496—Transitional care management services (decision making of high complexity)</td>
<td>Use CPT Codes -- 99495 &amp; 9946.</td>
<td></td>
</tr>
</tbody>
</table>

## Transitional Care Management

<table>
<thead>
<tr>
<th>Face-to-face Visit</th>
<th>Proposed Rule</th>
<th>CPT TCM Codes</th>
<th>Medicare CY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separately billed face-to-face E/M visit within 30 days prior to the hospital discharge or within the first 14 days of the 30-day period of TCM services</td>
<td>Face-to-face visit within 14 calendar days of discharge (99495), or within 7 calendar days (99496). The first face-to-face visit is part of the TCM service and not reported separately. E/M services after the first face-to-face visit may be reported separately.</td>
<td>Use CPT requirements.</td>
<td></td>
</tr>
</tbody>
</table>
### Transitional Care Management

<table>
<thead>
<tr>
<th><strong>Proposed Rule</strong></th>
<th><strong>CPT TCM Codes</strong></th>
<th><strong>Medicare CY 2013</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship to Patient</strong></td>
<td>The patient may be new to the physician’s practice (provided the face-to-face visit requirements above are met).</td>
<td>The reporting physician or NPP must have an established relationship with the patient.</td>
</tr>
</tbody>
</table>

### Discharge Management

<table>
<thead>
<tr>
<th><strong>Proposed Rule</strong></th>
<th><strong>CPT TCM Codes</strong></th>
<th><strong>Medicare CY 2013</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge Management</strong></td>
<td>The physician or NPP who bills for discharge management services during the time period covered by TCM services may not also bill for GXXX1.</td>
<td>A physician or NPP may report both the discharge code and appropriate TCM code.</td>
</tr>
</tbody>
</table>
# Transitional Care Management

<table>
<thead>
<tr>
<th>Proposed Rule</th>
<th>CPT TCM Codes</th>
<th>Medicare CY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Global Services</strong></td>
<td>The physician who reports a service with a global period of 010 or 090 days may not also report the TCM service.</td>
<td>The physician who reports a service with a global period of 010 or 090 days may not also report the TCM service.</td>
</tr>
<tr>
<td></td>
<td>However, the AMA recommends that specialties work on a CPT proposal for a new code to describe extensive post-discharge TCM services.</td>
<td>The physician who reports a service with a global period of 010 or 090 days may not also report the TCM service.</td>
</tr>
</tbody>
</table>

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# Anesthesia Section
Anesthesia Guidelines

►Anesthesia Services◄
►Services rendered in the office, home, or hospital; consultation; and other medical services are listed in the Evaluation and Management Services section beginning on page 11 (99201-99499). “Special Services and Reporting” (99000-99091) are listed in the Medicine section.◄

Anesthesia Guidelines

►Supplied Materials◄
►Supplies and materials provided (eg, sterile trays, drugs) over and above those usually included with the office visit or other services rendered may be listed separately. Drugs, tray supplies, and materials provided should be listed and identified with 99070 or the appropriate supply code.◄
General Surgery

Surgery Guidelines

Guidelines to direct general reporting of services are presented in the Introduction. Some of the commonalities are repeated here for the convenience of those referring to this section on Surgery. Other definitions and items unique to Surgery are also listed.

Services

Services rendered in the office, home, or hospital, consultations, and other medical services are listed in the Evaluation and Management Services section (99201-99499), beginning on page 11. “Special Services and Reports” (99000-99091) are listed in the Medicine section.
CPT Surgical Package Definition

By their very nature, the services to any patient are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services “included” in a given CPT surgical code, the following services are always included in addition to the operation per se:

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

Supplied Materials

- Supplies and materials (eg, sterile trays/drugs), over and above those usually included with the procedure(s) rendered are reported separately. List drugs, trays, supplies, and materials provided. Identify as 99070 or specific supply code.

Reporting More Than One Procedure/Service

- When more than one procedure/service is performed on the same date, same session or during a post-operative period (subject to the “surgical package” concept), several CPT modifiers may apply (see Appendix A for definition).

Separate Procedure

Some of the procedures or services listed in the CPT codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term “separate procedure.” The codes designated as “separate procedure” should not be reported in addition to the code for the
Random vs Anatomically Named

Random
• Flaps that have no known vessel supplying them.
• They do not have as reliable a blood supply.
• Use Adjacent Tissue Transfer codes for random island flaps.

Axial
• Unlike random flaps, axials have specific identifiable vessels.
0299T  Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound

0300T  each additional wound (List separately in addition to code for primary procedure)

- Use 0300T in conjunction with 0299T
- Do not report 0300T in conjunction with 28890, 0101T, 0102T when treating same area

Rationale
Two Category III codes 0299T, 0300T were established to report the treatment of extracorporeal shock wave for the integumentary system wound healing, high energy, including topical application and dressing care. Code 0299T is intended to report the initial wound, and code 0300T is an add-on code for each additional wound. This procedure includes a high-energy, noninvasive, biological response activating device utilized by individuals for the repair and regeneration of tissue. Because of its high energy and Class III status, an individual assesses and monitors the patient for any adverse tissue events, such as bleeding, petechiae and hematoma, as well as pain.

To exemplify the intended use for these codes, an instructional parenthetical note was added to indicate that the primary code 0299T is appropriately reported in conjunction with the add-on code 0300T. An exclusionary parenthetical note was also added to preclude the reporting of code 0300T in conjunction with other existing extracorporeal shockwave treatment codes 28890, 0101T and 0102T.
Musculoskeletal System - General

Introduction or Removal

▲ 20665 Removal of tongs or halo applied by another physician-individual

General change throughout CPT

Musculoskeletal System - Arthrodesis

Anterior or Anterolateral Approach Technique

22554 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

► (Do not report 22554 in conjunction with 63075, even if performed by a separate individual. To report anterior cervical disectomy and interbody fusion at the same level during the same session, use 22551) ▼

63075 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace

22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2

No change in any of these CPT code descriptions!
Musculoskeletal System - Arthrodesis

New code for arthrodesis spine

- 22586  Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace;

► (Do not report 22586 in conjunction with 20930-20938, 22840, 22848, 72275, 77002, 77003, 77011, 77012) ◄

New code that pretty much bundles all integral/related components.

Rationale

To redirect users regarding the appropriate codes to report for identifying arthrodesis using the pre-sacral interbody technique, a parenthetical note has been added following arthrodesis code 22586.

Code 22586 is used to report arthrodesis using a presacral interbody technique. The procedure inherently includes all effort necessary to perform the fusion procedure. This includes preparation of the disc space (at L5-S1), discectomy at this level, posterior instrumentation, imaging necessary for provision of the procedure, and bone grafting performed at the level of arthrodesis for this procedure. As a result, a parenthetical note has been added following code 22586 that restricts use of this code in conjunction with all procedures previously noted (20930-20938, to identify bone grafting at this level; 22840 and 22848, to identify posterior instrumentation at the presacral interbody fusion level; and 72275, 77002, 77003, 77011, and 77012, to identify imaging needed to perform the procedure). An additional parenthetical note has been placed following code 22558, which directs users to appropriate codes to identify open (22586) and percutaneous (0195T) presacral interbody fusion techniques. In addition, also see the discussion regarding CPT nomenclature reporting neutrality for more information on the change to the parenthetical following code 22554. To further clarify the intention, exclusionary parenthetical notes have been added following the aforementioned imaging code to direct users to the correct codes to identify this procedure.
Shoulder and Elbow Arthroplasty: Implant Removal

- CCI edit: cannot report implant removal with total elbow or total shoulder arthroplasty when a “revision” procedure is performed

- Revision: remove one prosthesis and replace with another

- New codes for revision of total elbow and total shoulder arthroplasty (includes removal of prosthesis)

- Not really a new guideline, but a clarification.

Shoulder

23330  Removal of foreign body, shoulder; subcutaneous
23331  deep (eg, Neer hemiarthroplasty removal)
23332  complicated (eg, total shoulder)

► (Do not report 23331, 23332 in conjunction with 23473, 23474 if a prosthesis [ie, humeral and/or glenoid component(s)] is being removed and replaced in the same shoulder) ➾

- 23473   Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
- 23474   humeral and glenoid component

► (Do not report 23473, 23474 in conjunction with 23331, 23332 if a prosthesis [ie, humeral and/or glenoid component(s)] is being removed and replaced in the same shoulder) ➾
Humerus (Upper Arm) and Elbow

24160 Implant removal; elbow joint
► (Do not report 24160 in conjunction with 24370 or 24371 if a prosthesis [ie, humeral and/or ulnar component(s)] is being removed and replaced in the same elbow)

24164 Implant removal, radial head

24363 Arthroplasty elbow with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
► (For revision of total elbow implant, see 24370, 24371)

• 24370 Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component

• 24371 humeral and ulnar component
► (Do not report 24370, 24371 in conjunction with 24160 if a prosthesis [ie, humeral and/or ulnar component(s)] is being removed and replaced in the same elbow)

Rationale
As part of the RUC Relativity Assessment Workgroup (RAW) (formerly the Five-Year Review Identification Workgroup) analysis of codes, a need for additional codes for reporting revision of a total elbow arthroplasty, including the removal of the prosthesis and replacement with a new prosthesis (artificial implant) was identified. Originally, the removal component of the elbow revision procedure (24363) was reported separately with code 24160, but codes 24363 and 24160 were not recognized when reported together and payment denials occurred. The new codes describe the revision of a total elbow arthroplasty that includes the removal of an artificial prosthesis (ie, humeral and/or ulnar component[s]) and replacement with a new prosthesis (artificial implant) in the same elbow. The term “revision” in the new codes refers to removal of a prosthesis and replacement with a new prosthesis at the same time. A series of instructional parenthetical notes have been added to disallow the use of 24160 in conjunction with 24370 or 24371 and to reference the new revision of elbow codes following the total elbow arthroplasty code 24363.
Humerus (Upper Arm) and Elbow

Clinical Example (24370)
A 68-year-old female had a total elbow arthroplasty 15 years ago has pain and limited motion with radiographic evidence of component loosening. She undergoes revision of the humeral component.

Description of Procedure (24370)
Under anesthesia, a posterior elbow incision is made. The ulnar nerve is identified for protection throughout the dissection. The triceps and extensor mechanism are released from their insertion on the ulna and then displaced in a radial direction. The elbow joint is exposed, scar tissue is excised, and contractures are released from the humerus for exposure and soft tissue balancing. Extraction instruments are used to remove the loose humeral component. Meticulous preparation and cleansing of the humeral canal, including fibrous membrane and cement removal, is necessary prior to the placement of the prosthetic humeral component. A burr and saw along with cutting guides are used to cut the proximal ulna or the distal humerus as necessary. After a trial component is inserted in a correct position, the final component is inserted using cement to complete the procedure. Judgment and technical skill are necessary to carefully align the component with the proper degree of rotation. The tourniquet is released, hemostasis is obtained, the collateral ligaments are repaired, and the triceps tendon/extensor mechanism is reapproximated to the proximal ulna. The subcutaneous tissue is approximated, and the skin is closed.

Foot and Toes - Other Procedures

28890 Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia;

(For extracorporeal shock wave therapy involving integumentary system not otherwise specified, see 0299T, 0300T)

(Do not report 28890 in conjunction with 0299T, 0300T when treating the same area)
Dennis Brown Splint: CPT Deleted

29590 Strapping; to a Dennis-Brown bar (splint) with manipulation and casting (e.g. for metatarsus adductus)

• 2012 CPT accepted specialty societies request to revise code descriptor
• Survey: descriptor problematic – includes manipulation and cast
• Pre-fabricated splint is typically used

Application of Casts and Strapping

Lower Extremity

29581 Application of multi-layer compression system; leg (below knee), including ankle and foot

► (Do not report 29581 in conjunction with 29540, 29580, 29582, 36475, 36478)◄

29582 thigh and leg, including ankle and foot, when performed

► (Do not report 29582 in conjunction with 29540, 29580, 29581, 36475, 36478)◄

29583 upper arm and forearm

► (Do not report 29583 in conjunction with 29584)◄

29584 upper arm, forearm, hand, and fingers

► (Do not report 29584 in conjunction with 97140)◄

Manual therapy techniques was removed from do not code lists!
Endoscopy/Arthroscopy

29861  Arthroscopy, hip, surgical; with removal of loose body or foreign body
29916  with labral repair

 ► (Do not report 29916 for labral repair secondary to acetabuloplasty or in conjunction with 29915, 29862, 29863) ▼

Language was simplified in instruction (and CPT 29915 added to list).
Trachea and Bronchi Endoscopy: Changes to Existing Parenthetic Phrases

- **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

  ► (Do not report 31634 in conjunction with 31647, 31651 at the same session)

- **31635** with removal of foreign body

  ► (For removal of implanted bronchial valves, see 31648-31649)

Trachea and Bronchi Endoscopy: New Codes

- **31647** with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe

Example:

A 64-year-old female with a persistent air leak after a surgical resection. Air leak (bronchopleural fistula) has not resolved with chest tube to suction for several days. During the bronchoscopy, the leak is identified in one lobe and bronchial valve(s) is inserted.

Replaced 0250T, 0251T, 0252T (new for CPT 2011!)
Trachea and Bronchi Endoscopy: New Codes

- **31648** with removal of bronchial valve(s), initial lobe

Example:
A 64-year-old female had endobronchial valve(s) placed in a single lobe for control of a persistent air leak. Removal of the valve(s) is indicated from one lobe.

(For removal and insertion of a bronchial valve at the same session, see 31647, 31648, and 31651)

Replaced 0250T, 0251T, 0252T (new for CPT 2011!)

- **31649** with removal of bronchial valve(s), each additional lobe
  (List separately in addition to code for primary procedure)

Example:
A 59-year-old male had endobronchial valve(s) placed in more than one lobe for control of a persistent air leak. Removal of the valves from both lobes is indicated. The valve from the first lobe has been removed (reported separately) and now the second valve is removed.

Replaced 0250T, 0251T, 0252T (new for CPT 2011!)
Trachea and Bronchi Endoscopy: New Codes

31651  with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])

Example:
A 64-year-old female with a persistent air leak after a surgical resection. Air leak (bronchopleural fistula) has not resolved with chest tube to suction for several days. Leak has not resolved with bronchial valve(s) insertion into one lobe and a leak has been identified in an additional lobe, and bronchial valve(s) is inserted.

(Use 31651 in conjunction with 31647)
(31656 has been deleted. To report, use 31899)

Replaced 0250T, 0251T, 0252T (new for CPT 2011!)

Bronchial Thermoplasty - New Codes

31660  Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe

31661  with bronchial thermoplasty, 2 or more lobes

Replaced 0276T, 0277T new for CPT 2012!
Bronchial Thermoplasty

- **Non-drug** procedure for severe persistent asthma in adults.
- For asthma not well controlled through inhaled corticosteroids and long-acting beta-agonists.
- Delivers thermal energy to the airway wall in a precise and controlled way to reduce excessive airway smooth muscle which decreases the ability of the airways to constrict which reduces the frequency of attacks.
- Bronchoscopically-performed in 3 outpatient procedure visits:
  - Each visit treats a different area of the lungs
  - Visits are scheduled approximately 3 weeks apart
  - Routinely performed under moderate sedation

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**Bronchial Thermoplasty Coverage – Con**

UpToDate – “…additional data are needed regarding long-term effects and morphologic changes in the airways prior to determining when to use BT.”

BCBS IL – “…considered experimental, investigational and unproven…”

CIGNA – Policy 0502: “…considered experimental, investigational or unproven.”

UnitedHealthCare – Policy 2012T0542D “…unproven for treating asthma.”
Bronchial Thermoplasty Coverage – Pro

FDA – approved Thermoplasty System for adults with severe asthma, despite inhaled glucocorticoids and long-acting beta agonists

California Technology Assessment Forum – “...use of bronchial thermoplasty for the treatment of severe, refractory asthma meets CTAF TA Criterion 1 through 5 for safety, effectiveness and improvement in net health outcomes.”

craf.org/sites/default/files/assessments/1381_file_BTSevereAsthma_W4.pdf

Medicare - Many Medicare contractor LCDs – no coverage of Category III codes, but now Category I; and paid since 1/1/12 in Outpatient Hospital for Transitional Pass-through with codes: C1886, Catheter, extravascular tissue ablation, any modality (insertable); C9730 or C9731 for device

Individual coverage on case-by-case basis (United HealthCare, HCSC, BCBS, Anthem, Aetna, CIGNA, Humana, Medical Mutual of Ohio, Molina Medical, BCBS Carefirst)

American Thoracic Society – “…declaring bronchial thermoplasty as experimental is inconsistent with existing literature, not in the best interest of patients and ultimately not in the best financial interests of ______...the literature clearly demonstrates the clinical effectiveness and bronchial thermoplasty should no longer be considered experimental.”

American College of Chest Physicians – similar letter moving through approval; for posting on public website

Lungs and Pleura Revisions

► (32420 has been deleted. To report, use 32405) ◄
► (32421 and 32422 have been deleted. To report, see 32554, 32555) ◄
► (Do not report 32503, 32504 in conjunction with 19260, 19271, 19272, 32100, 32551, 32554, 32555) ◄

32420 Pneumocentesis, puncture of lung for aspiration
32421 Thoracentesis, puncture of pleural cavity for aspiration, —initial or subsequent
32422 Thoracentesis with insertion of tube, includes water seal — (eg, for pneumothorax), when performed (separate procedure)
Lungs and Pleura Revisions

Introduction and Removal

© ▲ 32551 Tube thoracostomy, includes connection to drainage system (eg, water seal) (eg, for abscess, hemothorax, empyema), when performed, open (separate procedure)

Lungs and Pleura New Codes

- 32554 Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance
- 32555 with imaging guidance
- 32556 Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance
- 32557 with imaging guidance

► (For insertion of indwelling tunneled pleural catheter with cuff, use 32550) ◄
► (For open procedure, use 32551) ◄
► (Do not report 32554-32557 in conjunction with 32550, 32551, 76942, 77002, 77012, 77021, 75989) ◄
Stereotactic Radiation Therapy
New Guidelines

Thoracic stereotactic body radiation therapy (SRS/SBRT) is a distinct procedure which may involve collaboration between a surgeon and radiation oncologist. The surgeon identifies and delineates the target for therapy. The radiation oncologist reports the appropriate code(s) for clinical treatment planning, physics and dosimetry, treatment delivery and management from the Radiation Oncology section (see 77295, 77331, 77370, 77373, 77435). The same physician should not report target delineation services with radiation treatment management codes (77427-77499).

Target delineation involves specific determination of tumor borders to identify tumor volume and relationship with adjacent structures (eg, chest wall, intraparenchymal vasculature and atelectatic lung) and previously placed fiducial markers, when present. Target delineation also includes availability to identify and validate the thoracic target prior to treatment delivery when a fiducial-less tracking system is utilized.

Do not report target delineation more than once per entire course of treatment when the treatment requires greater than one session.
Stereotactic Radiation Therapy

- **32701** Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment

  - Do not report 32701 in conjunction with 77261-77799
  - (For placement of fiducial markers, see 31626, 32553)

*Technology is now approved for this px to be performed in the thoracic region.*

*This code is not to be used to duplicate any work already included in the radiation therapy codes and can only be used once per course of treatment.*
Pacemaker/Pacing Cardioverter-Defibrillator

Conversion of existing system to bi-ventricular system (addition of LV lead and removal of current pulse generator with insertion of new pulse generator with bi-ventricular pacing capabilities)

33225 + 33228 or 33229

33225 + 33263 or 33264

Cardiovascular System - Heart and Pericardium

▲ 33225 Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including eg, for upgrade to dual chamber system and pocket revision) (List separately in addition to code for primary procedure);

► (Use 33225 in conjunction with 33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33221, 33222, 33228, 33229, 33230, 33231, 33233, 33234, 33235, 33240, 33249, 33263, 33264)

► (Use 33225 in conjunction with 33222 only with pacemaker pulse generator pocket relocation and with 33223 only with pacing cardioverter-defibrillator [ICD] pocket relocation)
Heart (Including Valves) and Great Vessels

Patients receiving major cardiac procedures may require simultaneous cardiopulmonary bypass insertion of cannulae into the venous and arterial vasculatures with support of circulation and oxygenation by a heart-lung machine. Most services are described by codes in dyad arrangements to allow distinct reporting of procedures with or without cardiopulmonary bypass. Cardiopulmonary bypass is distinct from support of cardiac output using devices (eg, ventricular assist or intra-aortic balloon). For cardiac assist services see 33960-33983, 33990-33993.

Now includes cardiac valve procedure codes and distinguishes cardiopulmonary bypass from support of cardiac output using cardiac assist services (new codes).

Cardiac Valves
Aortic Valve - New Guidelines

Codes 33361-33365, 0318T are used to report transcatheter aortic valve replacement (TAVR)/transcatheter aortic valve implantation (TAVI). TAVR/TAVI requires two physician operators and all components of the procedure are reported using modifier 62.

Codes 33361-33365, 0318T include the work, when performed, of percutaneous access, placing the access sheath, balloon aortic valvuloplasty, advancing the valve delivery system into position, repositioning the valve as needed, deploying the valve, temporary pacemaker insertion for rapid pacing (33210), and closure of the arteriotomy when performed. Codes 33361-33365, 0318T include open arterial or cardiac approach.

Angiography, radiological supervision, and interpretation performed to guide TAVR/TAVI (eg, guiding valve placement, documenting completion of the intervention, assessing the vascular access site for closure) are included in these codes.
Cardiac Valves
Aortic Valve - New Guidelines

Diagnostic left heart catheterization codes (93452, 93453, 93458-93461) and the supravalvular aortography code (93567) should not be used with TAVR/TAVI services (33361-33365, 0318T) to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TAVR/TAVI,
2. Aorta/left ventricular outflow tract measurement for the TAVR/TAVI, or
3. Post-TAVR/TAVI aortic or left ventricular angiography, as this work is captured in the TAVR/TAVI services codes (33361-33365, 0318T).

Cardiac Valves
Aortic Valve - New Guidelines

Diagnostic coronary angiography performed at the time of TAVR/TAVI may be separately reportable if:

1. No prior catheter-based coronary angiography study is available and a full diagnostic study is performed, or
2. A prior study is available, but as documented in the medical record:
   a. The patient's condition with respect to the clinical indication has changed since the prior study, or
   b. There is inadequate visualization of the anatomy and/or pathology, or
   c. There is a clinical change during the procedure that requires new evaluation.
   d. For same session/same day diagnostic coronary angiography services, report the appropriate diagnostic cardiac catheterization code(s) appended with modifier 59 indicating separate and distinct procedural service from TAVR/TAVI.
Cardiac Valves
Aortic Valve - New Guidelines

Diagnostic coronary angiography performed at a separate session from an interventional procedure may be separately reportable.

Other cardiac catheterization services are reported separately when performed for diagnostic purposes not intrinsic to TAVR/TAVI.

When transcatheter ventricular support is required in conjunction with TAVR/TAVI, the appropriate code should be reported with the appropriate ventricular assist device (VAD) procedure code (33990-33993, 33975, 33976, 33999) or balloon pump insertion code (33967, 33970, 33973).

The TAVR/TAVI cardiovascular access and delivery procedures are reported with 33361-33365, 0318T. When cardiopulmonary bypass is performed in conjunction with TAVR/TAVI, codes 33361-33365, 0318T should be reported with the appropriate add-on code for percutaneous peripheral bypass (33367), open peripheral bypass (33368), or central bypass (33369).

Aortic Valve New Codes

- **33361** Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
- **33362** open femoral artery approach
- **33363** open axillary artery approach
- **33364** open iliac artery approach
- **33365** transaortic approach (eg, median sternotomy, mediastinotomy)
  ► (Use 0318T for transapical approach [eg, left thoracotomy])

+ **33367** cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)

  ► (Use 33367 in conjunction with 33361-33365, 0318T)
  ► (Do not report 33367 in conjunction with 33368, 33369)
Aortic Valve - New Codes

**+● 33368**  cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels)  
(List separately in addition to code for primary procedure)

► (Use 33368 in conjunction with 33361-33365, 0318T) ◄
► (Do not report 33368 in conjunction with 33367, 33369) ◄

**+● 33369**  cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery)  
(List separately in addition to code for primary procedure)

► (Use 33369 in conjunction with 33361-33365, 0318T) ◄
► (Do not report 33369 in conjunction with 33367, 33368) ◄

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**Aortic Valve - New Codes**

**● 0318T**  Implantation of catheter-delivered prosthetic aortic heart valve, open thoracic approach, (eg, transapical, other than transaortic)

Category III code 0318T is for the transapical approach for TAVR. When peripheral access is inadequate, placement of an intracardiac prosthesis (ie, stent or valve) can be achieved through transthoracic cardiac exposure via mediastinal, thoracotomy, or subxiphoid approach.
Aortic Valve New Codes

FDA approved the transcatheter aortic valve replacement (TAVR) for patients with aortic valve stenosis who are not candidates for open surgery. These were Cat III codes 0256T-0259T.

1. As with a balloon angioplasty, in the TAVR, a catheter is threaded through an artery, then a balloon device on the end inflates to open a narrowing in an artery in the heart.
2. The replacement valve collapses to a very small diameter and is crimped onto the balloon device.
3. The surgeon positions the replacement valve inside the patient’s natural aortic valve and inflates the balloon.
4. This inflation causes the replacement valve to expand, pushing the faulty valve aside.
5. The replacement valve begins to function as soon as the balloon catheter deflates to permit the flow of blood.
Venous Grafting Only for Coronary Artery Bypass - New Guidelines

Procurement of the saphenous vein graft is included in the description of the work for 33510-33516 and should not be reported as a separate service or co-surgery. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs graft procurement, add modifier 80 to 33510-33516. For percutaneous ventricular assist device insertion, removal, repositioning, see 33990-33993.

Combined Arterial-Venous Grafting for Coronary Bypass New Guidelines

Procurement of the saphenous vein graft is included in the description of the work for 33517-33523 and should not be reported as a separate service or co-surgery. Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 35600 in addition to the bypass procedure. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier 80 to 33517-33523, 33533-33536, as appropriate. For percutaneous ventricular assist device insertion, removal, repositioning, see 33990-33993.
Arterial Grafting for Coronary Artery Bypass New Guidelines

► Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 35600 in addition to the bypass procedure. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier 80 to 33517-33523, 33533-33536, as appropriate. For percutaneous ventricular assist device insertion, removal, repositioning, see 33990-33993.

Cardiac Assist New Guidelines

► The insertion of a ventricular assist device (VAD) can be performed via percutaneous (33990, 33991) or transthoracic (33975, 33976, 33979) approach. The location of the ventricular assist device may be intracorporeal or extracorporeal.

For surgical insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO), use 36822.

Open arterial exposure when necessary to facilitate percutaneous ventricular assist device insertion (33990, 33991), may be reported separately (34812). Extensive repair or replacement of an artery may be additionally reported (eg, 35226 or 35286).

Removal of a ventricular assist device (33977, 33978, 33980, 33992) includes removal of the entire device, including the cannulas. Removal of a percutaneous ventricular assist device at the same session as insertion is not separately reportable. For removal of a percutaneous ventricular assist device at a separate and distinct session, but on the same day as insertion, report 33992 appended with modifier 59 indicating a distinct procedural service.
Cardiac Assist New Guidelines

Repositioning of a percutaneous ventricular assist device at the same session as insertion is not separately reportable. Repositioning of percutaneous ventricular assist device not necessitating imaging guidance is not a reportable service. For repositioning of a percutaneous ventricular assist device necessitating imaging guidance at a separate and distinct session, but on the same day as insertion, report 33993 with modifier 59 indicating a distinct procedural service.

► Replacement of the entire implantable ventricular assist device system, ie, pump(s) and cannulas, is reported using the insertion codes (ie, 33975, 33976, 33979). Removal (ie, 33977, 33978, 33980) of the ventricular assist device system being replaced is not separately reported. Replacement of a percutaneous ventricular assist device is reported using implantation codes (ie, 33990, 33991). Removal (ie, 33992) is not reported separately.

Cardiac Assist New Codes

- **33990** Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only
- **33991** both arterial and venous access, with transseptal puncture
- **33992** Removal of percutaneous ventricular assist device at separate and distinct session from insertion;
- **33993** Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion;

*Were Cat III codes (0048T, 0050T).*
Cardiac Assist New Codes

A percutaneous ventricular assist device (pVAD) is a mechanical pump that helps a weakened heart eject blood to the body decreasing the work of the weakened ventricle.

• Commonly used for patients with impaired ventricular function undergoing high-risk procedures (eg, complex endovascular coronary intervention).
• Can also be used for critically ill patients with severe ventricular dysfunction for medical stabilization.
• Mostly reported in conjunction with complex endovascular, percutaneous coronary, or valvular interventions.
• However, most endovascular, percutaneous coronary, or valvular interventions are done without the assistance of pVAD.

Open arterial exposure, when necessary for pVAD insertion (33991, 33992), may be reported separately (34812).

Because VAD removal of the entire device, including the cannulas, is inherent in codes 33977, 33978, and 33980, a new code (33992) has also been added for removal of a percutaneous ventricular assist device at a separate and distinct session, but on the same day as insertion. …use modifier 59.
Vascular Injection Procedures

Intravenous

- ▲ 36010  Introduction of catheter, superior or inferior vena cava

Intra-Arterial—Intra-Aortic

- 36120  Introduction of needle or intracatheter; retrograde brachial artery

- ▲ 36140  extremity artery

Moderate sedation (☉) has been added to CPT codes 36010 and 36140

Diagnostic Carotid Angiography

2013 - New Bundled CPT Coding

- RUC Relativity Assessment Workgroup
  - Reviews codes that are reported together more than 75% of the time
  - Prior examples include renal artery selective catheter/imaging, IVC filters, & LE arterial endovascular intervention
  - Multiple carotid radiology S&I codes flagged

- New CPT codes created for 2013
  - Non-selective & selective arterial catheterization
  - Cervical & cerebral carotid/vertebral arteriography
Diagnostic Carotid Angiography
2012 - Component Coding Guidelines

- Non-selective vs. Selective catheterization
  - 36200 vs. 36215 through 36218
- Imaging – unilateral vs. bilateral
  - Cervicocerebral arch 75650
  - Cervical carotid 75676 and 75680
  - Cerebral carotid 75665 and 75671
  - External carotid 75660 and 75662
  - Vertebral 75685

Diagnostic Carotid Angiography
2013 - Bundled Coding Guidelines

Now not for use with aortic arch, carotid, or vertebral catheterization

- Non-selective vs. Selective catheterization
  - 36200 vs. 36215 through 36218
- Imaging – unilateral vs. bilateral
  - Cervicocerebral arch 75650
  - Cervical carotid 75676 and 75680
  - Cerebral carotid 75665 and 75671
  - External carotid 75660 and 75662
  - Vertebral 75685
Diagnostic Carotid Angiography Definitions

- **Cervical carotid = Extracranial carotid**
  - Carotid artery outside the cranium
  - Extends from aortic arch to skull base

- **Cerebral carotid = Intracranial carotid**
  - Carotid artery inside the cranium
Diagnostic Carotid Angiography

- 36221 Arch aortogram plus non-selective aortic cath
- 36222 Unilateral innominate/CCA cath + cerv carotid imaging
- 36223 Unilateral innominate/CCA cath + cerv/cereb carotid imaging
- 36224 Unilateral ICA cath + cereb carotid imaging (+cervical)
- 36225 Unilateral innominate/subclavian cath + vert imaging
- 36226 Unilateral vertebral cath + vertebral imaging
  + 36227 Add-on external carotid (use w/ 36222-36224)
  + 36228 Add-on selective ICA/vertebral branch cath+imaging (max use of 36228 = 4)

36222 thru 36226 include arch imaging (36221), if performed

Modifier -50 appropriate for a bilateral evaluation

Diagnostic Carotid Angiography
2013 Bundled Coding

Includes (do not code separately):

- Accessing the vessel
- Non-selective aortic and selective innominate, carotid, and vertebral artery catheterization
- Contrast injection(s) of the aortic arch and carotid/vertebral systems (including arterial, capillary, and venous phase, when performed)
- Fluoroscopy
- Radiological S&I
- Closure of the arteriotomy by pressure, or application of an arterial closure device

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Diagnostic Carotid Angiography
2013 Bundled Coding

Excludes (code in addition):

- Interventional procedures
  - Embolization
  - Angioplasty
  - Endovascular stent placement
- Ultrasound guidance for access (eg, 76937)
- Selective arterial catheterization of vascular families outside the carotid and vertebral arteries
- 3-D rendering (eg, 76376 or 76377)

Aortic Arch Anatomy
Diagnostic Carotid Angiography
Arch Angiography

• 2012 Guidelines
  – Catheterization  36200
  – Imaging  75650

• 2013 Guidelines
  – Bundled service  36221

• Description of carotid and/or vertebral arteries without selective catheterization of the great vessels is an arch angiogram.

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Diagnostic Carotid Angiography
Arch Angiography

• For reporting purposes, remember that 36221 includes a non-selective aortic catheterization.

• Simultaneous aortic arch and abdominal aortography is reported:
  – In 2012:  75650, 75625, and 36200
  – In 2013:  36221, 75625 (no additional 36200)
Arch angiography (36221) is bundled into the selective carotid codes (36222-36224)

Description of carotid arteries without selective catheterization of the great vessels → 36221

Follow-up imaging without further catheter selection (higher order) is bundled (i.e., no 75774)
Diagnostic Carotid Angiography
Arch Angiography + Selective Carotid

- **36222**
  - Innominate or CCA catheterization + extracranial carotid imaging

- **36223**
  - Innominate or CCA catheterization + extracranial & intracranial carotid imaging

- **36224**
  - Selective ICA catheterization + intracranial carotid imaging (includes extracranial carotid)
Diagnostic Carotid Angiography
Arch Angiography + Selective Carotid

36222 - Innominate or CCA catheterization + extracranial carotid imaging

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Diagnostic Carotid Angiography
Arch Angiography + Selective Carotid

- **36222**
  - Innominate or CCA catheterization + extracranial carotid imaging

- **36223**
  - Innominate or CCA catheterization + extracranial & intracranial carotid imaging

- **36224**
  - Selective ICA catheterization + intracranial carotid imaging (includes extracranial carotid)

E.g., Bovine arch anatomy

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Diagnostic Carotid Angiography
Arch Angiography + Selective Carotid

- The only difference between 36222 and 36223 is the absence/presence of intracranial carotid artery imaging
- Both include the same selective arterial catheterization and extracranial carotid imaging
- 36222 → Extracranial
- 36223 → Extracranial AND Intracranial

Diagnostic Carotid Angiography
Arch Angiography + Selective Carotid

- 36222
  - Innominate or CCA catheterization + extracranial carotid imaging
- 36223
  - Innominate or CCA catheterization + extracranial & intracranial carotid imaging
- 36224
  - Selective ICA catheterization + intracranial carotid imaging (includes extracranial carotid)
Diagnostic Carotid Angiography
Arch Angiography + Selective Carotid

36224 - ICA selective catheterization + intracranial carotid imaging
Diagnostic Carotid Angiography
Arch Angiography + Selective Carotid

- CPT code 36224
  - Selective catheterization of the ICA
  - Intracranial carotid angiography
  - Extracranial carotid imaging is NOT required
  - However, if extracranial carotid imaging is performed, it is bundled with code description (like the arch aortogram)

Diagnostic Carotid Angiography
Arch Angiography + Selective Carotid

- Hierarchy of services based on level of selection (36224 > 36223 > 32222)

- Unilateral descriptions so only one of these three codes applicable per side

- Bilateral identical procedures, use modifier -50

- Bilateral procedures with different hierarchies, use modifier -59 on lesser code in the hierarchy
Diagnostic Carotid Angiography
Example #1

From a femoral artery puncture, the catheter is advanced to the ascending aorta for an arch aortogram. The innominate and then the right common carotid artery is selected. Extracranial and intracranial imaging is performed. The catheter is withdrawn back into the aorta and the left common carotid artery is selected. Extracranial and intracranial imaging is performed.

Diagnostic Carotid Angiography
Example #2

From a femoral artery puncture, the catheter is advanced to the ascending aorta for an arch aortogram. The innominate and then the right common carotid artery is selected. Extracranial and intracranial imaging is performed. The catheter is withdrawn back into the aorta and the left common carotid artery is selected. Only extracranial imaging is performed.
Diagnostic Carotid Angiography
External Carotid

• If ECA not selected, 36227 not applicable

• The ECA is ALWAYS selected after the common carotid artery is selected
  – Therefore, CPT code 36227 can only be reported with either 36222, 36223, or 36224

• Further catheter selection (higher order) within the ECA is bundled

• Follow-up imaging within the ECA is bundled (i.e., 75774 not reportable)
Diagnostic Carotid Angiography
External Carotid

Arch Angiography + Selective Vertebral

- Arch angiography (36221) is bundled into the selective vertebral codes (36225, 36226)

- Description of vertebral arteries without selection of great vessels → 36221

- Follow-up imaging without further catheter selection (higher order) is bundled (i.e., no 75774)
Diagnostic Carotid Angiography
Arch Angiography + Selective Vertebral

- Hierarchy of services based on level of selection
  (36226 > 36225)

- Only one of these two codes per side

- Bilateral identical procedures, use -50

- Bilateral procedures with different hierarchies, use modifier -59 on ↓ code

Diagnostic Carotid Angiography
Arch Angiography + Selective Vertebral

- **36225**
  - Innominate or subclavian catheterization + vertebral/basilar imaging

- **36226**
  - Vertebral catheterization + vertebral/basilar imaging
Diagnostic Carotid Angiography
Arch Angiography + Selective Vertebral

36225 - Innominate or SCA catheterization + vertebral imaging

Diagnostic Carotid Angiography
Arch Angiography + Selective Vertebral

36225 - Innominate or SCA catheterization + vertebral imaging
Diagnostic Carotid Angiography
Arch Angiography + Selective Vertebral

- **36225**
  - Innominate or subclavian catheterization + vertebral/basilar imaging

- **36226**
  - Vertebral catheterization + vertebral/basilar imaging
Diagnostic Carotid Angiography
Arch Angiography + Selective Vertebral

ICA
ECA
CCA
Vertebral
Subclavian
Ascending Aorta
Descending Thoracic Aorta

36226 - Vertebral catheterization + vertebral imaging

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Diagnostic Carotid Angiography  
ICA/Vertebral Additional Catheterization

- 36228 - Unilateral selective arterial catheter placement and diagnostic imaging of the initial and each additional intracranial branch of the internal carotid or vertebral arteries
  - Further selection within the branch is bundled
  - Requires use of either 36224 or 36226
  - Maximum use of 36228 is twice per side but requires separate branch off ICA/vertebral
  - E.g., MCA cath + imaging is 36224, 36228

Intravascular Thrombolysis  
2013 - New Bundled CPT Coding

- RUC Relativity Assessment Workgroup
  - Reviews codes that are reported together more than 75% of the time
  - Prior examples include renal artery selective catheter/imaging, IVC filters, & LE arterial endovascular intervention
  - Thrombolysis procedure and the radiology S&I codes flagged
- New CPT codes created for 2013
  - Bundling of the procedure code and radiology S&I
Intravascular Thrombolysis 2013 - New Bundled CPT Coding

Intraprocedural injection(s) of a thrombolytic agent is an included service and not separately reportable in conjunction with mechanical thrombectomy. However, subsequent or prior continuous infusion of a thrombolytic is not an included service and is separately reportable (see 37211-37214).

Transcatheter Thrombolytic Infusion

Codes 37211 or 37212 are used to report the initial day of transcatheter thrombolytic infusion(s) including follow-up arteriography/venography, and catheter position change or exchange, when performed. To report bilateral thrombolytic infusion through a separate access site(s), use modifier 50 in conjunction with 37211, 37212. Code 37213 is used to report continued transcatheter thrombolytic infusion(s) on subsequent day(s), other than initial day and final day of treatment. Code 37214 is used to report final day of transcatheter thrombolytic infusion(s). When initiation and completion of thrombolysis occur on the same day, report only 37211 or 37212.

Code(s) for catheter placement(s), diagnostic studies, and other percutaneous interventions (eg, transluminal balloon angioplasty, stent placement) provided may be separately reportable.

Codes 37211-37214 include fluoroscopic guidance and associated radiological supervision and interpretation.

Ongoing evaluation and management services on the day of the procedure related to thrombolysis are included in 37211-37214. If a significant, separately identifiable E/M service is performed by the same physician on the same day of the procedure, report the appropriate level of E/M service and append modifier 25.

Ultrasound guidance for vascular access is not included in 37211-37214. Code 76937 may be reported separately when performed if all the required elements are performed.
Intravascular Thrombolysis

- Non-selective and selective catheterization remains separately reportable
- New codes are based on date of service
- Simultaneous deletions
  - Code 37201 (thrombolysis)
  - Codes 37209 and 75900 (catheter exchange)
- No longer applicable with thrombolysis
  - Code 75896 (non-thrombolytic infusions - 37202)
  - Code 75898 (follow-up angio after embolization or non-thrombolytic infusions)

# 37211 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day
# 37212 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day
# 37213 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;
# 37214 cessation of thrombolysis including removal of catheter and vessel closure by any method

➤(Report 37211-37214 once per date of treatment)➤
➤(For declotting by thrombolytic agent of implanted vascular access device or catheter, use 36593) ➤

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Intravascular Thrombolysis

- Codes based on an entire day of treatment
  - Midnight to midnight time period
- Only one of these 4 codes reported per day
- Initiation of a thrombolytic infusion
  - Arterial thrombolytic infusion 37211
  - Venous thrombolytic infusion 37212
- Follow-up day thrombolytic infusion, imaging, exchange of catheter (if performed)
  - Continued therapy for another day 37213
  - Termination of therapy on that day 37214

Intravascular Thrombolysis
2013 Bundled Coding

Includes (do not code separately):
- Institution of thrombolytic infusion
- Radiological supervision and interpretation
- All repeat imaging and catheter exchange(s) on that day of therapy – no matter how many
- Moderate sedation
- Ongoing E/M services on that day related to thrombolysis (excluding initial evaluation for institution of therapy)
Intravascular Thrombolysis
2013 Bundled Coding

Excludes (may code in addition):
• Non-selective and selective catheterization
• Diagnostic imaging
• Initial E&M for institution of therapy
• Endovascular intervention
  – Mechanical thrombectomy
  – Angioplasty, stent, atherectomy
• IVC filter insertion / repositioning / removal
• Ultrasound guidance for vascular access
  – E.g., 76937

Intravascular Thrombolysis

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Days</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start/complete on 1 day</td>
<td>Day 1</td>
<td>37211 or 37212</td>
</tr>
<tr>
<td>Two day course of therapy</td>
<td>Day 1</td>
<td>37211 or 37212</td>
</tr>
<tr>
<td></td>
<td>Day 2</td>
<td>37214</td>
</tr>
<tr>
<td>Three day course of therapy</td>
<td>Day 1</td>
<td>37211 or 37212</td>
</tr>
<tr>
<td></td>
<td>Day 2</td>
<td>37213</td>
</tr>
<tr>
<td></td>
<td>Day 3</td>
<td>37214</td>
</tr>
<tr>
<td>Four day course of therapy (RARE)</td>
<td>Day 1</td>
<td>37211 or 37212</td>
</tr>
<tr>
<td></td>
<td>Day 2</td>
<td>37213</td>
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<tr>
<td></td>
<td>Day 3</td>
<td>37213</td>
</tr>
<tr>
<td></td>
<td>Day 4</td>
<td>37214</td>
</tr>
</tbody>
</table>

NOTE: Day 1 will always be 37211 or 37212
NOTE: Middle days will always be 37213
NOTE: Last day will always be 37214
Intravascular Foreign Body Retrieval

2013 - New Bundled CPT Coding

• RUC Relativity Assessment Workgroup
  – Reviews codes that are reported together more than 75% of the time
  – Prior examples include renal artery selective catheter/imaging, IVC filters, & LE arterial endovascular intervention
  – Intravascular foreign body retrieval procedure and the radiology S&I codes flagged
• New CPT code created for 2013
  – Bundling of the procedure code and radiology S&I

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Intravascular Foreign Body Retrieval

• 37197 Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed

• Non-selective and selective catheterizations remain separately reportable
• New code is based on a combination of procedure code and radiology S&I
• Simultaneous deletions of 37203 / 75961
• Please note - IVC filter removal → 37193
• Includes moderate sedation
• Includes imaging guidance (U/S & fluoro)
**Guideline Revision:**

When treating multiple vessels within a territory, report each additional vessel using an add-on code, as applicable. Select the base code that represents the most complex service using the following hierarchy of complexity (in descending order of complexity): atherectomy and stent > atherectomy > stent > angioplasty. When treating multiple lesions within the same vessel, report one service that reflects the combined procedures, whether done on one lesion or different lesions, using the same hierarchy.

*Paragraph added to define hierarchy in LE endovascular arterial intervention*
Bone Marrow or Stem Cell Services/Procedures

• 3 parenthetical notes added to the Bone Marrow or Stem Cell to provide clarification on appropriate reporting of codes 38220-38230.

• 1 note instructs users to report code 38220 for needle aspiration of bone marrow for the purposes of bone grafting.

• Another instructs users not to report codes 38220-38230 for bone marrow aspiration for platelet-rich stem cell injections, but to report code 0232T instead.

• The last note instructs to code 38220 for bone marrow aspiration.
  – Code 38220 may be used for needle aspiration of bone marrow for the purpose of bone grafting or aspiration of bone marrow for diagnostic purposes.
  – Although the parenthetical instruction following code 20938 directs users to code 38220, in this instance code 38220 involves aspiration of bone marrow for grafting in an arthrodesis procedure.

  • When the bone marrow is obtained prior to the arthrodesis, the placement of the bone marrow aspirate is included as part of the arthrodesis procedure and is not reported separately.
Hematopoietic cell transplantation (HCT) refers to the infusion of hematopoietic progenitor cells (HPC) obtained from bone marrow, peripheral blood apheresis, and/or umbilical cord blood. These procedure codes (38240-38243) include physician monitoring of multiple physiologic parameters, physician verification of cell processing, evaluation of the patient during as well as immediately before and after the HPC/lymphocyte infusion, physician presence during the HPC/lymphocyte infusion with associated direct physician supervision of clinical staff, and management of uncomplicated adverse events (e.g., nausea, urticaria) during the infusion, which is not separately reportable.

In response to concerns regarding valuation in the family of codes 38240-38242, several changes and additions have been made.
Transplantation and Post-Transplantation Cellular Infusions

• new subsection heading added along with introductory language and guidelines for appropriate reporting of these services.
• codes 38240, 38241, and 38242 have been editorially revised.
• code 38243 has been established to report HPC boost.
• parenthetical notes following code 38242 have been revised to provide direction for appropriate reporting of these services.
• cross-reference has been added in the Pathology and Laboratory/Transfusion Medicine section of the CPT code set following code 86950 directing users to the appropriate code for reporting allogeneic lymphocyte infusion (38242).
Gastroenterology

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

43206  with optical endomicroscopy
► (Report supply of contrast agent separately) ◄
► (Do not report 43206 in conjunction with 88375) ◄

43234  Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)
► (43234 has been deleted. To report, use 43235) ◄

43235  Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

43252  with optical endomicroscopy
► (Report supply of contrast agent separately) ◄
► Do not report 43252 in conjunction with 88375) ◄
► (For biopsy specimen pathology, use 88305) ◄

Codes 43206, 43252, and 88375 have been established to identify real-time cellular observation of intestinal tissue during an endoscopy.

- 43206 – optical endomicroscopy performed with esophagoscopy
- 43252 – optical endomicroscopy performed with EGD
  - Both include moderate sedation
  - Both include diagnostic injection procedures for contrast agent (supply of contrast agent itself is not included)
  - Both include the interpretation and report for the service (88375 should not be reported in conjunction with these codes)
Gastroenterology

Optical endomicroscopy:
- In vivo microscopic imaging
- Facilitates real-time cellular observation of mucosal tissue during endoscopy
- When there is suspicion of early stage pre-neoplastic/dysplasia disease.
- Allows better identification of anatomical sites for a more targeted bx.
- Avoids random biopsies, which has a high likelihood of missing abnormal tissue.
- Allows physician to make real-time therapeutic decisions that would otherwise require multiple biopsy procedures.

Category III, Vagus Nerve Blocking Therapy

- Electrode array and pulse generator
- For treatment of obesity
- Six new codes
  - Implantation, Revision, Replacement, Removal, Analysis
- Procedures performed for vagus nerve stimulation other than esophagogastric junction, report 64568-64570
**Category III Codes**

**A cross reference following code 43648**

- (For laparoscopic implantation, revision, replacement, removal or reprogramming of vagus nerve blocking neurostimulator electrode array and/or pulse generator at the esophagogastric junction, see 0312T-0317T)

  - **0312T** Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming
  - **0313T** laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator
  - **0314T** laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator

**Category III Codes**

- **0315T** removal of pulse generator
- **0316T** replacement of pulse generator

- (Do not report 0315T in conjunction with 0316T)

- **0317T** neurostimulator pulse generator electronic analysis, includes reprogramming when performed

- (For implantation, revision, replacement, and/or removal of vagus [cranial] nerve neurostimulator electrode array and/or pulse generator for vagus nerve stimulation performed other than at the EGJ [eg, epilepsy], see 64568-64570)

- (For analysis and/or [re]programming for vagus nerve stimulator, see 95970, 95974, 95975)
**Gastroenterology**

43882  Revision or removal of gastric neurostimulator electrodes, antrum, open;

► (For open implantation, revision, or removal of gastric lesser curvature or vagal trunk (EGJ) neurostimulator electrodes, [morbid obesity], use 43999)◄

**Gastroenterology**

44705  Preparation of fecal microbiota for instillation, including assessment of donor specimen

► (Do not report 44705 in conjunction with 74283)◄
► (For fecal instillation by oro-nasogastric tube or enema, use 44799)◄

- Fecal Microbiota Transplantation (FMT)
- Infusion of healthy colonic flora to treat antibiotic-resistant C difficile infections, ulcerative colitis, chronic constipation and potentially Crohn’s and some autoimmune diseases.
- An extract of healthy bacteria from the stool of a donor is suspended in a solution, which is then preserved.
- On the day of the procedure, the solution is thawed, delivered to the patient via enema, and retained for four to six hours.
- Sometime it may be delivered via nasogastric tube or colonoscope.
Fecal Microbiota RUC Review

- CMS did not accept the RUC recommendation RVU for 44705, but created HCPCS Code G0455

- Concern is Medicare payment for the preparation of the donor specimen would only be made if the specimen is ultimately used for the treatment of a beneficiary.

- To bill for CPT code 44705 please use HCPCS code G0455 (Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen).

- **2013 HCPCS Code G0455 = 0.97**
## 2013 MFS

### ADDENDUM B. - RELATIVE VALUE UNITS AND RELATED INFORMATION USED IN DETERMINING MEDICARE PAYMENTS FOR CY 2013

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<th>CPT/HCPCS</th>
<th>Mod</th>
<th>Status</th>
<th>Description</th>
<th>Physician Work RVUs</th>
<th>Non-Facility PE RVUs</th>
<th>Facility PE RVUs</th>
<th>Mal-Practice RVUs</th>
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<td>0.28</td>
<td>000</td>
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</tbody>
</table>

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**Surgery – Maternity Care and Delivery**
Maternity Care and Delivery

Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. When reporting delivery only services (59409, 59514, 59612, 59620), report inpatient postdelivery management and discharge services using Evaluation and Management Services codes (99217-99239). Delivery and postpartum services (59410, 59515, 59614, 59622) include delivery services and all inpatient and outpatient postpartum services. Medical complications of pregnancy (eg, cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, preterm labor, premature rupture of membranes, trauma) and medical problems complicating labor and delivery management may require additional resources and may be reported separately, and should be identified by utilizing the codes in the Medicine and Evaluation and Management Services in addition to codes for maternity care.

For medical complications of pregnancy (eg, cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, pre-term labor, premature rupture of membranes), see services in the Medicine and Evaluation and Management Services section.
Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System

• 64561 was editorially revised to state "including image guidance, if performed"
  – So don’t add the imaging guidance to this code.

• Cross-reference following code 64570 regarding vagus nerve stimulation procedures
  – Do not report 64570 in conjunction with 61888.

Chemodenervation

• Destruction by Neurolytic Agent heading revised
• Guidelines revised
  – These codes include injecting other agents which should not be coded separately.
  – Do not report a destruction code when therapies are not destructive to target nerve (unlisted code instead).
  – Chemodenervation agent reported separately.
Chemodenervation

• 3 instructional notes moved to follow the guidelines + 1 new instruction:

► (For chemodenervation of internal anal sphincter, use 46505)
► (For chemodenervation of the bladder, use 52287)
► (For chemodenervation for strabismus involving the extraocular muscles, use 67345)
► (For chemodenervation guided by needle electromyography or muscle electrical stimulation, see 95873, 95874)

Chemodenervation, continued

Somatic Nerves

▲ 64612 Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (e.g., for blepharospasm, hemifacial spasm)
► (To report a bilateral procedure, use modifier 50)

64613 neck muscle(s) (e.g., for spasmodic torticollis, spasmodic dysphonia)
► (Report 64613 only once per session)
► (Do not report 64613 with modifier 50)

▲ 64614 extremity and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis)
► (Report 64614 only once per session)

● 64615 muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (e.g., for chronic migraine)
► (Report 64615 only once per session)
► (Do not report 64615 in conjunction with 64612, 64613, 64614)
Surgery – Eye and Ocular Adnexa

OPHTHALMOLOGY
Eye and Ocular Adnexa
(Anterior Segment – Anterior Chamber)

▲ 65800 Paracentesis of anterior chamber of eye (separate procedure);
with diagnostic aspiration removal of aqueous

65805 – with therapeutic release of aqueous
► (65805 has been deleted. To report, use 65800)◄

Paracentesis of anterior chamber of eye with therapeutic release of aqueous was similar to paracentesis of anterior chamber of eye with diagnostic aspiration of aqueous thus, code 65805 was deleted and the service incorporated into code 65800

New terminology states: “with removal of aqueous” which encompasses both the diagnostic and therapeutic release of aqueous.

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66982 – Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage.

► (For insertion of ocular telescope prosthesis including removal of crystalline lens, use 0308T)

66983 – Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)

► (Do not report 66983 in conjunction with 0308T)

66984 – Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)

(For complex extracapsular cataract removal, use 66982)

► (For insertion of ocular telescope prosthesis including removal of crystalline lens, use 0308T)
Ø 0308T Insertion of ocular telescope prosthesis including removal of crystalline lens

(Do not report 0308T in conjunction with 65800-65815, 66020, 66030, 66600-66635, 66761, 66825, 66982-66986, 69990)

New Category III code for implantation of a prosthetic intraocular telescope to treat central vision loss due to end-stage age-related macular degeneration.

Implantation of the telescope is a new procedure that is not described by any current CPT code. The physician work is significantly different from any other corneal or cataract procedure, involving the removal of the lens because it includes insertion and implantation of a telescope into the lens capsule. The telescope is structurally and functionally different from any other device that is inserted into the lens capsule.

# ▲ 67810 – Biopsy Incisional biopsy of eyelid skin including lid margin

(For biopsy of skin of the eyelid, see 11100, 11101, 11310-11313)

Clarify the depth and type of biopsy required when malignancy is suspected.

Distinguish it from codes 11100 and 11101, which are in the Integumentary System and are more often performed for benign lesions.
Radiology Guidelines: Supervision and Interpretation

Imaging may be required during the performance of certain procedures or certain imaging procedures may require surgical procedures to access the imaged area. Many services include image guidance, which is not separately reportable and is so stated in the descriptor or guidelines. When imaging is not included in a surgical procedure or procedure from the Medicine section, image guidance codes or codes labeled “radiological supervision and interpretation” may be reported for the portion of the service that requires imaging. Both services require image documentation and radiological supervision, interpretation, and report services require a separate interpretation.

When a procedure is performed by two individuals physicians, the radiologic portion of the procedure is designated as “radiological supervision and interpretation.” When a physician the same individual performs both the procedure and provides imaging supervision and interpretation, a combination of procedure codes outside the 70000 series and imaging supervision and interpretation codes are to be used.

Bronchography

- Clinically, bronchography has almost entirely been replaced by CT
- Codes 71040 and 71060 have been deleted

71040 Bronchography, unilateral, radiological supervision and interpretation;

71060 Bronchography, bilateral, radiological supervision and interpretation

► (71040, 71060 have been deleted. To report, use 76499)
Cervical Spine Radiography

▲ 72040 Radiologic examination, spine, cervical; 23 views or 3— —viewsless

▲ 72050  4minimum of  or 5 views

▲ 72052      complete, including oblique and flexion and/or extension studies more views

• Codes 72040, 72050, 72052 have been revised
• Now, more clearly define the services performed
• And, more clearly reflect current clinical practice

Aortography

• Cross reference notes following codes 75600 and 75605 have been updated
• Supports restructured Medicine section (CPT 2011)
• In CPT 2011, the diagnostic catheterization codes in the Medicine section were restructured to include imaging supervision, interpretation, and report
• In support of the changes, the notes following codes 75600 and 75605 have been revised to direct users to report code 93567 for supravalvular aortography, when performed at the time of cardiac catheterization
Aortography

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

► (For injection procedures supravalvular aortography performed at the time of cardiac catheterization, use 93567, which includes imaging supervision, interpretation, and report) ▶

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

► (For injection procedures supravalvular aortography performed at the time of cardiac catheterization, use 93567, which includes imaging supervision, interpretation, and report) ▶

Aortography & Angiography

• Codes 75650, 75660, 75662, 75665, 75671, 75676, 75680, and 75685 have been deleted

• Now, combined or bundled into codes 36221-36228

• Parenthetical notes have been updated and/or deleted for codes 75625, 75741, 75743, 75746, 75756

• Supports restructured Medicine section (CPT 2011)
Arteriography

- New instructional added to report code 75774 for diagnostic angiography of upper extremities and other vascular beds performed in the same session
- Cross-reference note related to introduction of catheter has been updated with new code ranges for cardiac catheter procedures

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

(Use 75774 in addition to code for specific initial vessel studied)

► (Do not report 75774 as part of diagnostic angiography of the extracranial and intracranial cervicocerebral vessels. It may be appropriate to report 75774 for diagnostic angiography of upper extremities and other vascular beds performed in the same session)

► (For introduction of catheter, injection procedure cardiology catheterization procedures, see 93451-93452-93462, 93530-93531-93533, 93563-93568)
Transcatheter Therapy

▲75896 Transcatheter therapy, infusion, any method (eg, thrombolysis other than coronary) for thrombolysis, radiological supervision and interpretation

▶(For radiological supervision and interpretation for thrombolysis other than coronary, see 37211-37214)
▶(Do not report 75896 in conjunction with 37211-37214)

▲75898 Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis

▶(For thrombolysis infusion management other than coronary, see 37211-37214)
▶(Do not report 75898 in conjunction with 37211-37214)

Thrombolytic infusion is not an inclusive service and is separately reportable with the new combined transcatheter services 37211-37214

Transcatheter Therapy

• Code 75900 has been deleted
  – Previously reported when a previously placed intravascular catheter was exchanged during thrombolytic therapy
  – Service is now included in codes 37211-37214

• Code 75961 has been deleted and service is now reported with 37211
Drainage Guidance

75989  Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation

►(Do not report 75989 in conjunction with 32554, 32555, 32556, 32557, 47490)◄

New parenthetical has been added to code 75989 to note restrictions on use for thoracocentesis procedures

Breast Ultrasound

76645 Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation

►(Do not report 76645 in conjunction with 0301T)◄

New parenthetical note has been added to indicate that 0301T should not be reported with ultrasound codes (this is one example)

● 0301T Destruction/reduction of malignant breast tumor with externally applied focused microwave, including interstitial placement of disposable catheter with combined temperature monitoring probe and microwave focusing sensocatheter under ultrasound thermotherapy guidance

►(Do not report 0301T in conjunction with 76645, 76942, 76998, 77600-77615)◄

Many exclusions
Ultrasound Guidance

**76942** Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

► (Do not report 76942 in conjunction with 27096, 32554, 32555, 32556, 32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 64479-64484, 64490-64495, 76975, 0213T-0218T, 0228T-0231T, 0232T, 0249T, 0301T)

Parenthetical note for code 76942 has been updated to include new codes for tube thoracostomy, thoracentesis, pleural drainage, paravertebral facet joint injections using ultrasound, and applied focused microwave

Fluoroscopic Guidance

**77002** Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)

► (Do not report 7700277002 in addition to conjunction with 32554, 32555, 32556, 32557, 70332, 73040, 73085, 73115, 73525, 73580, 73615, 0232T)

Parenthetical note has been revised following code 77002 to restrict use of this code for thoracentesis and pleural fluid drainage procedures.
Fluoroscopic Guidance

**77003** Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

►(Do not report 77002, 77003 in conjunction with 22586, 27096, 64479-64484, 64490-64495, 64633-64636, 0195T, 0196T, 0309T)

Parenthetical notes for code 77003, 77011-77012 have been revised to exclude the use of this code in conjunction with any of the pre-sacral spinal fusion procedures

Magnetic Resonance Guidance

**77021** Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation

►(Do not report 77021 in conjunction with 32554, 32555, 32556, 32557, 0232T)

Exclusionary parenthetical note following code 77021 has been revised to restrict use of this code in conjunction with thoracocentesis procedures and pleural fluid drainage
Radiation Treatment Management

• Instructional note updated to include thoracic target delineation code

• Clarifies that the same physician s/n report both stereotactic radiosurgery services and radiation treatment management

• The phrase "for extracranial lesions“ deleted from the note to be consistent with current clinical practice for SRS/SBRT

77435 Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

(Do not report 77435 in conjunction with 77427-77432)

► (The same physician should not report both stereotactic radiosurgery services [32701, 63620, 63621] and radiation treatment management [77435] for extracranial lesions)

Microwave Breast Tumor Therapy

● 0301T Destruction/reduction of malignant breast tumor with externally applied focused microwave, including interstitial placement of disposable catheter with combined temperature monitoring probe and microwave focusing sensocatheter under ultrasound thermotherapy guidance

► (Do not report 0301T in conjunction with 76645, 76942, 76998, 77600-77615)

77600 Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)

77605 deep (ie, heating to depths greater than 4 cm)

► (For focused microwave thermotherapy of the breast, use 0301T)
Nuclear Medicine

Nuclear Thyroid Imaging

• Codes 78000-78011 have been deleted
• Three new codes (78012-78014) have been added to describe thyroid uptake and imaging procedures
• Parenthetical notes have been revised to include reference to new codes

Parathyroid Nuclear Imaging

• Changes have been implemented to update and modernize the Nuclear Medicine/Diagnostic Endocrine System subsection in the CPT code set
• These include revisions and additions to the current parathyroid codes

Nuclear Thyroid Imaging

78000  Thyroid uptake; single determination
78001  multiple determinations
78003  stimulation, suppression or discharge (not including initial uptake studies)
78006  Thyroid imaging; with uptake; single determination
78007  multiple determinations
78010  Thyroid imaging; only
78011  with vascular flow

►(78000-78011 have been deleted. To report, see 78012-78014)◄
Nuclear Thyroid Imaging

- **78012** Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)

- **78013** Thyroid imaging (including vascular flow, when performed);

- **78014** with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)

Parathyroid Nuclear Imaging

- **78070** Parathyroid planar imaging (including subtraction, when performed);

- **78071** with tomographic (SPECT)

- **78072** with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization
Summary

• Imaging services are increasingly being revised in CPT to bundle services commonly performed together into single codes
• Most changes in radiology this year are once again modifications and deletions
• Inventory the services your practice provides
• If you are performing any of these services, you must comply with new codes for 2013
Pathology and Laboratory Changes

- Evocative/Suppression Testing
- Molecular Pathology
- Multianalyte Assays with Algorithmic Analyses
- Chemistry
- Immunology
- Tissue Typing
- Transfusion Medicine
- Microbiology
- Surgical Pathology

Evocative/Suppression Testing – Guideline Changes

- Editorial revisions to reflect entire family of therapeutic infusion codes
- Reference to Prolonged services codes deleted (not appropriate due to time interval identified for typical therapeutic infusion)
- Deletion of 99070 for separate identification of supplies
Evocative/Suppression Testing — Guideline Changes

The following test panels involve the administration of evocative or suppressive agents and the baseline and subsequent measurement of their effects on chemical constituents. These codes are to be used for the reporting of the laboratory component of the overall testing protocol. For the physician’s administration of the evocative or suppressive agents, see Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration (eg, 96360, 96361, 96365, 96366, 96367, 96368, 96372, 96374, 96375, 96376); for the supplies and drugs see 99070. To report physician attendance and monitoring during the testing by a physician or other qualified health care professional, use the appropriate evaluation and management code, including the prolonged physician care codes (99354-99357) if required. Prolonged physician services care codes (99354-99357) are not separately reported when evocative/suppression testing involves prolonged infusions reported with 96360, 96361, 96365, 96366, 96367. In the code descriptors where reference is made to a particular analyte (eg, Cortisol: 82533 x 2) the “x 2” refers to the number of times the test for that particular analyte is performed.

Consultations (Clinical Pathology)

►A clinical pathology consultation is a service, including a written report, rendered by the pathologist in response to a request from a physician or qualified health care professional in relation to a test result(s)…”
Molecular Pathology (MoPath)

• What is it again?
  – Medical lab procedures involving analyses of nucleic acids to detect variants in genes that may be indicative of germline or somatic disease, or to test for histocompatibility antigens
  – Does not include infectious disease or in situ hybridization analyses (found in the Microbiology and Anatomic Pathology sections, respectively)

Molecular Pathology (MoPath)

  – Special 5-page insert within front section of Professional Edition CPT codebook
    • Offers additional information for Tier1/2
    • Explains abbreviations within code descriptors
    • Includes FAQ’s!
Molecular Pathology (MoPath)—Deleted Codes/Sections

- “Stacking” codes 83890-83914 – deleted*
- Array-based evaluation codes (88384-88386) – deleted*
- Appendix I (Genetic Testing Modifiers) – deleted*
- Tiers 1 and 2 used in replacement
- Creation of **81479** (Unlisted molecular pathology procedure) to be use for analyses not captured in Tiers 1 and 2

* and all associated cross-references/parentheticals.

Molecular Pathology (MoPath)

**Tier 1**

- Now contains 105 codes
- Includes 13 new codes for Molecular Pathology for 2013
- Used with gene-specific genomic procedures
- Code selection based on specific gene being analyzed
- Gene description according to Human Genome Organization (HUGO) namin
Molecular Pathology (MoPath)

Tier 1

• Gene name represented by an abbreviation
  – Abbreviation listed first
  – Followed by full gene name italicized in parentheses
• Examples (“eg.”) do not represent all conditions in which testing of the gene may be indicated.
• Reference MoPath Intro guidelines for details/instructions/definitions

Tier 1 – New codes example:

- **81201** APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence
- **81202** known familial variants
- **81203** duplication/deletion variants
Tier 2

- Report procedures not listed in Tier 1 molecular pathology codes (81200-81383)
- Represent medically useful procedures generally performed in lower volumes than Tier 1 (e.g., incidence of disease being tested is rare)
- Arranged by level of technical resources and interpretative work by physician/qualified health care professional

Tier 2

- Utilize Tier 1 coding principles and guidelines
- Code listing is not all inclusive
- Parenthetical examples of methodologies presented near beginning of code provide guidelines regarding intended use of that level of code
Molecular Pathology (MoPath)

Tier 2 – Guideline revision:
• Note to use level of Tier 2 code that includes specific listed analyte after root code descriptor
• If analyte tested is not listed in Tier 1 or 2, new instruction specifies use of unlisted pathology code 81479

Molecular Pathology (MoPath)

Tier two analyte additions
• 81400- 9 additions
• 81402- 2 additions
• 81403- 15 additions
• 81404- 22 additions
• 81405- 41 additions
• 81406- 14 additions
• 81407- 6 additions

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Molecular Pathology (MoPath)

• **Errata issues**
  – Tier 2 – Code revisions (analyte additions to each level):
    • 81401
      – Analyte APOB- apolipoprotein B (*eg, familial hypercholesterolemia type B*), common variants (*eg, R3500Q, R3500W*) was inadvertently listed at end of descriptor of prior analyte (ADRB2)

Molecular Pathology (MoPath)

• The College of American Pathologists (CAP) developed physician work RVU recommendations as well as practice expense direct inputs for medical supplies, equipment and clinical staff to the American Medical Association/Specialty Society RVS Update Committee (RUC) for the majority of the new molecular CPT codes developed by the AMA CPT Molecular Pathology Workgroup.

• The CPT Editorial Panel created 101 new molecular pathology CPT codes for CY 2012 and another 13 new molecular pathology codes for CY 2013.

• In 2011 the agency indicated hesitation in the placement of the new molecular pathology codes, either on the physician fee schedule or the clinical laboratory fee schedule.
Molecular Pathology (MoPath)

- In CMS final rule for 2013, CMS stated that these new CPT codes will not be paid on the Medicare physician fee schedule (PFS) and will be paid on the clinical laboratory fee schedule (CLFS).

- Further the CMS final rule, noted that CMS would not crosswalk these codes to the CLFS in 2013, rather that they will be gap-filled.

- CMS did publish the RUC valuations for these codes (PE and work). Hence are now available for pricing for other payors.

- CMS created a HCPCS code for the professional interpretation
  - G0452 Molecular pathology procedure; physician interpretation and report
  - Final rule indicated that CMS would not separately pay for PhD interpretations

Multianalyte Assays with Algorithmic Analyses (MAAAA)

Issue was spawn from the Molecular Pathology Workgroup who could not determine a mechanism within the Tier 1 & Tier 2 code set hierarchy to codify for these tests.
Multianalyte Assays with Algorithmic Analyses (MAAA)

Also referred to as IVDMIA’s (FDA)-- In vitro Diagnostic Multivariant Index Assays.

- Common thread between all of these tests- multiple data points (eg, lab results) combined in an algorithm to provide a result (eg, prognostic index, recurrence score, probably score)
- Typically these are single-source tests.

AMA-CPT IVDMIA Workgroup
Convened in July 2011, with a wide range of attendees from industry, organized medicine, CMS, and insurers present (>100).

And………………
Multianalyte Assays with Algorithmic Analyses (MAAA)

• Category I MAAA code set will function like traditional CPT codes
• An Administrative code list (Appendix O) will also be maintained by CPT that:
  – As a minimum standard it is an analysis that is generally available for patient care.
  – The AMA will not review procedures in the administrative code set for clinical utility.
• Neither proposed MAAA code set will be restricted solely to MoPath (none are! For 2013)

Multianalyte Assays with Algorithmic Analyses (MAAA)

  – New Category I Subsection
  – Utilize multiple results derived from:
    • MoPath assays
    • Fluorescent in situ hybridization
    • Other non-nucleic acid-based assays (proteins, polypeptides, lipids, carbohydrates)
    • All used as inputs into algorithmic analysis to derive a single result (numeric score/index/probability)
    • Generally available through a single lab/vendor
Multianalyte Assays with Algorithmic Analyses (MAAA)

– New subsection includes:
  • New Heading (Multianalyte Assays with Algorithmic Analysis)
  • Category I Introductory Guidelines
  • Includes an “Unlisted Multianalyte assay with algorithmic analysis code” (81599)

A few new codes
  ● 81500/3 – Ovarian cancer risk score
  ● 81506 – Diabetes risk score
  ● 81508, 81509, 81510, 81511, 81512 – Maternal serum screening for risk of fetal congenital abnormalities.
Multianalyte Assays with Algorithmic Analyses (MAAA)

- Appendix O additions:
  - 3 new Administrative MAAA codes
  - 8 new Cat I MAAA codes (also included in Appendix O table)
- Introductory guidelines include:
  - Provide specific guidance on how to report/assign codes
  - Specific requirements for inclusion in the Administrative code list/Cat. I

Multianalyte Assays with Algorithmic Analyses (MAAA)

- CPT understands need for rapid accessibility of these codes
- AMA CPT Web site features updates provided in March, June, and November
- These dates correspond to the CPT Editorial Panel actions for March, June, and November
Eight New Category I MAAAs codes (81500, 81503, 81506, 81508, 81509, 81510, 81511, 81512). None submitted to the RUC.

In CMS’ final ruling, CMS stated that these new CPT codes will not be valid for Medicare purposes for CY 2013. These molecular pathology codes appear in the physician fee schedule with a procedure status indicator of I (Not valid for Medicare purposes).
Chemistry – Revisions to Guidelines

Editorial changes noting coding instruction regarding appropriate coding for calculated analyte determinations using values derived from other analyses.

1. Clinical information or mathematically calculated values, which are not specifically requested by the ordering physician and are derived from the results of other ordered or performed laboratory tests, are considered part of the ordered test procedure(s) and therefore are not separately reportable service(s).

2. When the requested analyte result is derived using a calculation that requires values from nonrequested laboratory analyses, only the requested analyte code should be reported.

3. When the calculated analyte determination requires values derived from other requested and nonrequested laboratory analyses, the requested analyte codes (including those calculated) should be reported.
Chemistry – Revisions to Guidelines

4. An exception *(to the above)* is when an analyte (eg, urinary creatinine) is performed to compensate for variations in urine concentration (eg, microalbumin, thromboxane metabolites) in random urine samples; the appropriate CPT code is reported for both the ordered analyte and the additional required analyte.

5. When the calculated result(s) represent an algorithmically derived numeric score or probability, see the appropriate multianalyte assay with algorithmic analyses (MAAA) code or the MAAA unlisted code (81599).

Chemistry – Revisions

82000 Acetaldehyde, blood;

▲82009 Acetone or other Ketone body(s) (eg, acetone, acetoacetic acid, beta-hydroxybutyrate) serum; qualitative

▲82010 quantitative

- Specimen source removed
- Parenthetical list of examples (eg acetone, acetoacetic acid) describe ketone bodies within the descriptors
- Used to diabetic ketoacidosis management
Chemistry – Revisions

Changes to code 82277
  – Added to report Galectin-3 assay
    • Enzyme immunoassay that uses two highly specific monoclonal antibodies for direct measurement of Galectin-3 in human plasma and serum
    • Developed to measure:
      – Galectin-3
      – Related Galectins
    • Used to stratify patient prognoses with heart failure, independent of BNP results.

Immunology

Code Additions – 86152/3 (deletion of commensurate Category III codes 0279T, 0280T)

- 86152 Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood)
  ► (For physician interpretation and report, use 86153. For cell enumeration with interpretation and report, use 86152 and 86153)

- 86153 physician interpretation and report, when required
Tissue Typing

• **New codes for antibody to human leukocyte antigen (HLA) solid phase assays**
  – Platforms use solid phase assays covering most common HLA class I and II antigens
  – Technology uses microspheres, chips, ELISA trays coated with purified/recombinant HLA molecules
  – Testing used in the assessment of patients with platelet transfusion refractory thrombocytopenia & in solid organ transplant candidates that may have alloantibodies to HLA antigens.

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Tissue Typing

- **86828** Antibody to human leukocyte antigens (HLA), solid phase assays (eg, microspheres or beads, ELISA, flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to HLA Class I and Class II HLA antigens
- **86829** qualitative assessment of the presence or absence of antibody(ies) to HLA Class I or Class II HLA antigens
  ▶ (If solid phase testing is performed to assess presence or absence of antibody to both HLA classes, use 86828)
- **86830** antibody identification by qualitative panel using complete HLA phenotypes, HLA Class I
- **86831** antibody identification by qualitative panel using complete HLA phenotypes, HLA Class II
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86832</td>
<td>Antibody to human leukocyte antigens (HLA), solid phase assays (e.g., microspheres or beads, ELISA, flow cytometry); high definition qualitative panel for identification of antibody specificities (e.g., individual antigen per bead methodology), HLA Class I</td>
</tr>
<tr>
<td>86833</td>
<td>High definition qualitative panel for identification of antibody specificities (e.g., individual antigen per bead methodology), HLA Class II</td>
</tr>
<tr>
<td>86834</td>
<td>Antibody to human leukocyte antigens (HLA), solid phase assays (e.g., microspheres or beads, ELISA, flow cytometry); semi-quantitative panel (e.g., titer), HLA Class I</td>
</tr>
<tr>
<td>86835</td>
<td>Semi-quantitative panel (e.g., titer), HLA Class II</td>
</tr>
</tbody>
</table>
Tissue Typing

• Transfusion Medicine – Parenthetical
  – Cross-reference regarding processing and storage codes 86890 and 86891 retained in error.
  – Will be included in errata.
  – Correction found on website
  – Cross-reference after 86950 directs users to correct code for allogeneic lymphocyte infusion

Microbiology

Guideline Revisions

– Code Ranges for parenthetical notes following codes 87149, 87150, 87152 have been revised to reflect deletion of stacking codes 83890-83914 and replacement via insertion of codes 81200-81408
Microbiology

Addition of term “reverse transcriptase” to code descriptors

– Prior to 2013, infectious agent detection by nucleic acid (DNA or RNA) codes did not specifically note that reverse transcriptase was included within the procedure

– Codes 87498, 875121, 87522, 87535, 87536, 87538, 87539 descriptors revised to reflect inclusion of this procedure

Microbiology

New Codes – Infectious Agent Detection (Respiratory Viruses)

– Three new codes for Respiratory Viruses (87631, 87632, 87633)

– New codes accurately define number and potential types of respiratory viral targets simultaneously assessed.

– Instructional parentheticals added and existing notes revised for further clarification
### Microbiology

**87470** *Infectious agent detection by nucleic acid (DNA or RNA):*

- **87631** respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 3-5 targets

- **87632** respiratory virus (eg, adenovirus...), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 6-11 targets

- **87633** respiratory virus (eg, adenovirus ...), multiplex reverse transcription and amplified probe technique, multiple types or subtypes, 12-25 targets

### Surgical Pathology

**88375** Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session;

► (Do not report 88375 in conjunction with 43206 or 43252)◄

- 43206, 43252 – Identify the “surgical” procedure –
  Esophagoscopy with optical Endomicroscopy (43206) or EGD with Endomicroscopy (43252)

Note: Code 88375 is for interpretation of the specimens
Immunization Administration for Vaccines/Toxoids

Report codes 90460 and 90461 only when the physician or qualified health care professional provides face-to-face counseling of the patient and family during the administration of a vaccine. For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccines to patients over 18 years of age, report codes 90471-90474. (See also Instructions for Use of the CPT Codebook for definition of reporting qualifications)

*If a significant separately identifiable Evaluation and Management…*

90460  Immunization administration through…

*Edits refer users to the Introduction of CPT for definition of “QHP” vs “clinical staff”*
Comprehensive Psychiatry Section Update

Last major section update, **CPT 1998**:  
- 27 New Codes  
- 9 Code Revisions  
- 8 Code Deletions

New major section update, **CPT 2013**:  
- 11 New Codes  
- 4 Code Revisions  
- 27 Code Deletions
Impetus for Change

• Increased Intensity of Services due to increase in number of patient co-morbidities and complications without adequate codes

• Inadequate Psychotherapy Code Structure (eg, non-quantifiable levels of E/M service), New coding structure incorporates varying levels of E/M with varying levels of psychotherapy to address variations in work

• Interactive Psychotherapy/Diagnostic Interview Examination codes 90801, 90802 narrowly defined and inefficient

• Need to accurately reflect the different work performed by physicians and QHCP

Impetus for Change (cont’d)

• Account for dramatic changes in the practice of psychiatry and mental health since 1998 including:
  – Shift from treating single disorders to management of multiple disorders and medical co-morbidities
  – Drastic reductions in inpatient beds have shifted site of service from inpatient to outpatient, with more complex, higher risk patients being seen in outpatient settings
Comprehensive Psychiatry Section Update

What’s Different About the Update Process vs. 15 years ago:

• Increased Viability and Accountability
• RUC Recommendations and Input Received
• CPT Editorial Panel Workgroup Created
• Unbiased (No Practice Affiliations or Outside Interests) CPT Editorial Workgroup Chairs Appointed
• Consensus Process including Workgroup Surveys
• Workgroup Members Representative from all key Medical Specialty and Professional Groups

Comprehensive Psychiatry Section Workgroup

• American Academy of Child and Adolescent Psychiatry
• American Academy of Pediatrics
• American Nurses Association
• American Psychiatric Association
• American Psychiatric Nurses Association
• American Psychological Association
• National Association of Social Workers
New Structure of Psychiatry Coding

Psychiatric Diagnostic Evaluation

- 90801 (Diagnostic Interview Exam) replaced with 2 codes to differentiate between diagnostic evaluation with medical services (90792) and without medical services (90791)
- 90802 (Interactive Diagnostic Interview Exam) replaced with new add-on concept of “Interactive Complexity” (+90785)
Psychiatric Diagnostic Evaluation

Deleted:
90801 Psychiatric diagnostic interview examination

New:
- 90791 Psychiatric diagnostic evaluation
  - CPT Changes: An Insider’s View 2013
- 90792 Psychiatric diagnostic evaluation with medical services
  - CPT Changes: An Insider’s View 2013

Components:
- History and Mental Status
- Review and Order of Diagnostic Studies as needed
- Recommendations (including communication with family or other sources)

Medical Services Components, (includes above) plus the following:
- Examination (CMS psychiatric specialty examination)
- Prescription of Medications when appropriate
- Ordering of Laboratory Tests as needed
Psychiatric Diagnostic Evaluation
Coding Tips 90791, 90792

➤ Use for reassessment(s) if required

➤ Report more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants

➤ Do not report on the same day as psychotherapy or crisis psychotherapy

➤ Do not report on the same day as an E/M service performed by the same individual for the same patient

Interactive Complexity (+●90785)

Deleted:
90802
90810-90815
90823-90829

Interactive Psychiatric Diag. Interview Exam
Office/Outpat IA Psychotherapy
Inpat/Hosp IA Psychotherapy Codes

New:
● 90785

Interactive complexity (List separately in addition to the code for primary procedure)

tips:CPT Changes: An Insider’s View 2013

➤ (Use 90785 in conjunction with codes for diagnostic psychiatric evaluation [90791, 90792], psychotherapy [90832, 90834, 90837], psychotherapy when performed with an evaluation and management service [90833, 90836, 90838, 99201-99255, 99304-99337, 99341-99350], and group psychotherapy [90853])
Interactive Complexity (+90785)

Rationale:
Need existed to expand “interactive” concept to include specific and recognized effort required for communication difficulties for various types of patients and situations that represent significant complicating factors that increase the intensity of the primary psychiatric procedure.

When to Use Interactive Complexity (1 of the following must exist):

1. Maladaptive Communication (eg, high anxiety, high reactivity, repeated questions, or disagreement)

2. Emotional or Behavioral Conditions Inhibiting Implementation of Treatment Plan

3. Mandated Reporting/Event Exists (eg, abuse or neglect)

4. Play equipment, devices, interpreter, or translator required due to inadequate language expression or different language spoken between patient and professional
Interactive Complexity (+90785)

Coding Tip

- Interactive Complexity Relates to the Psychotherapy Service Only
- Interactive Complexity is not Factored into E/M
Interactive Complexity (+●90785)

Coding Tip

The amount of time spent by a physician or other qualified health care professional providing interactive complexity services should be reflected in the timed service code for psychotherapy (90832, 90834, 90837) or the psychotherapy add-on code performed with an evaluation and management service (+90833, +90836, +90838).

Psychotherapy with Patient or Family

Rationale:

• Site of service is no longer a criterion for code selection
• Time specifications are changed to be consistent with CPT convention
• “Individual” is not in the code titles and psychotherapy time may include face-to-face time with family members as long as the patient is present for part of the session
Psychotherapy with Patient or Family

Rationale (cont’d):
• Codes for psychotherapy with medical evaluation and management services have been replaced with psychotherapy add-on codes 90833, 90836, 90838 to be reported in conjunction with codes for E/M services.

Psychotherapy with Patient or Family

Intra-service work:
Face-to-face therapeutic communication is conducted with the patient and/or the patient's family. Objective information and an interval history are obtained. The patient's mental state is examined, including an evaluation and exploration of the intensity and complexity of the patient's symptoms, feelings, thoughts, and behaviors in the context of the patient's psychosocial and health stressors and coping styles. A range of psychotherapy approaches are used to reduce the patient's distress and morbidity, and ongoing behavioral and mental status changes in the patient are addressed.
Psychotherapy with Patient or Family

➢ To report both an E/M code and a psychotherapy add-on code (+90833, +90836, +90838), the two services must be significant and separately identifiable.

➢ The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision making.

Coding Tips

➢ Psychotherapy must be 16 minutes or more face-to-face with patient and/or family.
➢ Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service (i.e., time spent on history, examination, and medical decision making when used for the E/M service is not psychotherapy time).
➢ Time (Counseling and Coordination of Care) may not be used as the basis of E/M code selection.
➢ The E/M service and the psychotherapy service may be for the same diagnosis.
### Psychotherapy with Patient or Family

<table>
<thead>
<tr>
<th>Deleted Codes:</th>
<th>New Codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy <em>Outpatient, Non Interactive (Non IA)</em> 90804, 90806, 90808 <em>Inpatient, Non IA</em> 90816, 90818, 90821</td>
<td>Psychotherapy <em>All Sites of Service</em> ●90832, ●90834, ●90837</td>
</tr>
<tr>
<td>Psychotherapy, w/E/M <em>Outpatient, Non IA</em> 90805, 90807, 90809 <em>Inpatient, Non IA</em> 90817, 90819, 90822</td>
<td>Psychotherapy <em>All Sites of Service</em> +●90833, +●90836, +●90838 &quot;Add E/M Level of Service Code&quot;</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Deleted Codes:</th>
<th>New Codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy w/E/M INTERACTIVE <em>Outpt</em> 90810, 90812, 90814 <em>Inpat</em> 90823, 90826, 90828</td>
<td>Psychotherapy w/E/M <em>All Sites of Service</em> +●90833, +●90836, +●90838 &quot;Add E/M Level of Service Code&quot;</td>
</tr>
<tr>
<td>Psychotherapy w/E/M INTERACTIVE <em>Outpt</em> 90811, 90813, 90815 <em>Inpat</em> 90824, 90827, 90829</td>
<td>Psychotherapy w/E/M <em>All Sites of Service</em> +●90833, +●90836, +●90838 &quot;Add E/M Level of Service Code&quot;</td>
</tr>
</tbody>
</table>
Psychotherapy w/patient or family

Psychotherapy:
- 90832 (30 Minutes)
- 90834 (45 Minutes)
- 90837 (60 Minutes)

When a Medical E/M Service is Provided on Same Day Report:
- 99201-99255, 99304-99337, 99341-99350

Select Type & Level of E/M based on: History, Exam and Med Decision Making

Select Psychotherapy Add-on based on: Time

Note: Same diagnosis may exist for both Psychotherapy & E/M Services

E/M with Psychotherapy Add-on:
- +90833 (30 Minutes)
- +90836 (45 Minutes)
- +90838 (60 Minutes)

Psychotherapy with Patient or Family

- 90832: Psychotherapy, 30 minutes with patient and/or family member
- 90833: Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90834: Psychotherapy, 45 minutes with patient and/or family member
- 90836: Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- 90837: Psychotherapy, 60 minutes with patient and/or family member
- 90838: Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
CPT “Time Rule”

 “A unit of time is attained when the mid-point is passed”
 “When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used.”

With the Psychotherapy Codes:
   30 minutes (16-37 mins)
   45 minutes (38-52 mins)
   60 minutes (53+ mins)
 “Psychotherapy” never less than 16 minutes

CPT “Time Rule”

Examples
 Patient is seen for 40 minutes in the office for psychotherapy

Use code ●90834 (45 minutes psychotherapy)

 Pat is seen in the office for an E/M visit with psychotherapy. The nature of the patient’s presenting problem and documentation meets criteria for a 99212 level E/M code. In addition to time spent on the E/M portion of the visit, 20 minutes is spent providing psychotherapy services

Both 99212 and +●90833 (30 mins add-on) are reported
Psychotherapy with Patient or Family

Example of psychotherapy “with patient and/or family”

12-year-old with Attention Deficit Disorder presents for scheduled psychotherapy session with her parents. Her parents request to speak with the psychiatrist alone to discuss their concerns about possible substance abuse with their daughter. Part of the session is spent with the parents, followed by time spent with the patient.

Interim history is obtained from both the parents and the patient, relevant components of a mental status examination are completed with the patient, and the parents’ concerns are explored with the patient along with providing education regarding effects of substance use. The effects that symptoms of ADD are having on the patient’s relationships at school and home are discussed and a strategy for dealing with them is agreed upon. Specific recommendations are made to both the patient and her parents.

Code: 90837

Psychotherapy with Patient or Family

Example of E/M visit with psychotherapy

48-year old man was recently discharged from a brief inpatient psychiatric hospitalization after an overdose attempt. He has Bipolar disorder, mixed type and is currently on mood stabilizing, antidepressant, and antipsychotic medications, as well as an antihypertensive and medicine for GERD.

E/M: He is evaluated for suicide risk, manic and depressive behavior, and symptoms; beneficial effects, side effects, and med-med interactions; with concerns about elevations in his blood pressure since dosage changes on his psychiatric medications. A psychiatric specialty exam is completed and decisions made about modifications in his medication regimen. Risks and benefits are discussed.
Psychotherapy with Patient or Family

Example of E/M visit with psychotherapy (cont’d)

Psychotherapy:
Psychotherapy focuses on his concerns about his ability to return to work and “face his co-workers” as well as concerns that his children will “look down upon [him]” for being “weak.” Cognitive Behavioral Therapy (CBT) strategies are reviewed and agreed upon.

Coding:
The nature of the presenting problem and documentation of the elements meets criteria for 99213
Time spent in psychotherapy was 25 mins

Codes: 99213,±●90833

Psychotherapy with Patient or Family

Example of E/M visit with psychotherapy and interactive complexity

13-year-old in treatment for depression and alcohol abuse, on an antidepressant and an inhaler for her asthma, presents with both parents, who are divorced and arguing over how to address the patient’s recent alcohol binge. One parent wants to “send her away” to a boarding school. The other parent wants to follow the previously agreed upon course of treatment.

E/M: An interval history is obtained from parents and the patient, including details of recent alcohol use, along with exploration of other drug use, medication compliance, side effects, and beneficial effects. Suicide risk is explored. A psychiatric specialty exam is completed and decisions made about her medications. Risks and benefits are discussed.
Psychotherapy with Patient or Family

Example of E/M visit with psychotherapy and interactive complexity (cont’d)

Psychotherapy:
Psychotherapy focuses on her feelings about her father’s “new rules” at home during her weekends with him, and her anger at him for “embarrassing” her in front of her friend when he was drunk.

Interactive Complexity:
The intensity of work during the session is increased by the parents arguing with each other over the treatment recommended by the psychiatrist.

Coding:
The nature of the presenting problem and documentation of the elements meets criteria for a 99212
50 minutes is spent providing psychotherapy
The delivery of the service is complicated by the maladaptive communication involving the parents during the session

Codes: 99212, + 90836, + 90785
Family Psychotherapy (90846, 90847, 90849)

- Unchanged from 2012

- The focus of family psychotherapy is the family or subsystems within the family, e.g. the parental couple or the children, although the service is always provided for the benefit of the patient.

  - This is a distinguishing characteristic from the Psychotherapy with Patient or Family codes where the focus is on the individual patient with possible occasional involvement of family members.

Family Psychotherapy

- Use 90846 to report a service when the patient is not physically present.

- Use 90847 to report a service that includes the patient some or all of the time. Couples therapy is reported with code 90847.

- Use 90849 to report Multiple-Family Group Psychotherapy.

- Use 90853 to report Group Psychotherapy.
Group Psychotherapy

• Use Interactive Complexity add-on code +●90785 with 90853 to report for 1 or more group members

Examples:

➢ A group of 4 pre-school children, all of whom have witnessed traumatic events, are being treated in a group setting through the use of play therapy techniques

All participants may be billed as 90853,+●90785

➢ A group of 8 adults is being seen in a CBT Group, with the addition of an interpreter for one patient with a hearing impairment who utilizes a sign-language interpreter.

Only the one patient utilizing an interpreter may be billed 90853,+●90785

Group Psychotherapy (cont’d)

• Do NOT use Interactive Complexity (90785) in Multi Family Group Psychotherapy (90849) setting
90839: Psychotherapy for crisis; first 60 minutes

CPT Changes: An Insider’s View 2013

each additional 30 minutes (List separately in addition to code for primary service)

CPT Changes: An Insider’s View 2013

(Use 90840 in conjunction with 90839)

(Do not report 90839, 90840 in conjunction with 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services, or 90785-90899)

Crisis

Urgent

High Distress

Complex

Life Threatening

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Crisis Psychotherapy (90839-90840)

Rationale:
- New concept and addition to the psychotherapy section
- When psychotherapy services are provided to a patient who presents in high distress with complex or life threatening circumstances that require urgent and immediate attention

Crisis Psychotherapy

Rationale (cont’d):
- Do **not** report 90839, +90840 w/Dx Eval (90791, 90792), Psychotherapy (90832, 90834, 90837), or w/add-on Psychotherapy (+90833, +90836, +90838)
- Do **not** report 90839, +90840 w/Interactive Complexity (90785) or any of the procedures included in the Other Psychotherapy or Other Psychiatric Services or Procedures sections
Crisis Psychotherapy

- 90839 is a stand-alone code not to be reported with psychotherapy or psychiatric diagnostic evaluation codes, the interactive complexity code, or any other psychiatry section code.

- +90840 is an add-on code that should be reported for each additional 30 minutes of service.

Example:

36-year-old woman being treated for a Generalized Anxiety Disorder and relationship problems with Cognitive Behavior Therapy (a form of psychotherapy), calls and leaves a message that she is planning to commit suicide because she “can’t stand it anymore.” Her therapist is able to reach her on the phone and she agrees to come in for an urgent session in one hour. She arrives with her husband. The therapist attempts to defuse the crisis, meeting individually with the patient, and jointly with the husband. The patient remains suicidal, and is in agreement with hospitalization. The therapist makes arrangements for hospitalization and the patient is transported by ambulance. Total time spent on working with the patient and arranging for hospitalization is 95 minutes.

Codes: ●90839, +●90840
Crisis Psychotherapy

Coding Tips

• Report 90839 for the first 30-74 minutes of psychotherapy for crisis on a given date

• Psychotherapy for crisis of less than 30 min. total should be reported with 90832 or 90833

• Report 90839 only once per date even if time spent by the physician/QHCP is not continuous on that date

• When service results in additional time, report +90840 with 90839 once for every additional 30 minutes of time beyond the first 74 minutes

Psychiatric Section Revisions: Other Procedures

Deleted: 90857 Interactive Group Psychotherapy

Added: Crosswalk (Use IA code: 90785 with 90853):

90853 Group psychotherapy (other than of a multiple-family group)

► (Use 90853 in conjunction with 90785 for the specified patient when group psychotherapy includes interactive complexity)
Pharmacologic Management

Rationale:

• QHCP who are *not* authorized to report E/M codes may report the new add-on pharmacologic management code +●90863 in conjunction with psychotherapy codes (●90832, ●90834, ●90837)

• For pharmacologic management services provided by physicians and selected QHCP (i.e., psychiatric nurse practitioners), +●90863 should not be reported since pharmacologic management services are included in the E/M service.
Pharmacologic Management

Rationale (cont’d):

• Psychotherapy services do not include pharmacologic management

• Do not count time spent on providing pharmacologic management services in the time used for selection of the psychotherapy service

Psychiatric Section Revisions: Other Procedures

Revised: 90875 and 90876 to Exclude Time Ranges

▲ 90875  Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes

▲ CPT Assistant Nov 96:15, Sep 97:11, Nov 97:41, Apr 98:14, Jun 99:5, Mar 01:5, Mar 02:4, Mar 05:18, May 05:1; CPT Changes: An Insider’s View 2013

▲ 90876  45 minutes

▲ CPT Assistant Nov 96:15, Sep 97:11, Nov 97:41, Jun 99:5, Mar 01:5, Mar 05:16, May 05:1; CPT Changes: An Insider’s View 2013
### 2013 Work RVUs

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<th>Description</th>
<th>Value</th>
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<td>Interactive Complexity (List separately in addition to the code for primary procedure)</td>
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<td>Psychiatric diagnostic evaluation</td>
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<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
<td>2.96</td>
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<td>90832</td>
<td>Psychotherapy, 30 minutes with patient and/or family member</td>
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<tr>
<td>++90833</td>
<td>Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)</td>
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<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient and/or family member</td>
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<td>++90836</td>
<td>Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)</td>
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<td>Psychotherapy, 60 minutes with patient and/or family member</td>
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<td>++90838</td>
<td>Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure)</td>
<td>2.56</td>
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### 2013 Work RVUs

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<th>Code</th>
<th>Description</th>
<th>RVU</th>
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</thead>
<tbody>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
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</tr>
<tr>
<td>90840</td>
<td>each additional 30 minutes (List separately in addition to code for primary service)</td>
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</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
<td>1.79</td>
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<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present)</td>
<td>1.83</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present)</td>
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</tr>
<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
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</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
<td>0.59</td>
</tr>
</tbody>
</table>
2013 Work RVUs

| + 90863 | Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure) | Invalid for MCR |

Tip: Medicare uses M0064 for the reporting and payment of these services.

M0064 Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders

Medicine – Dialysis /Hemodialysis

(For prolonged physician attendance by a physician or other qualified health care professional, see 99354-99360)

▲ 90935 Hemodialysis procedure with single physician evaluation by a physician or other qualified health care professional

Edits emphasize provider neutrality
**Medicine – Dialysis / Hemodialysis**

▲ 90945 Dialysis procedure other than hemodialysis (e.g., peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single physician evaluation by a physician or other qualified health care professional

Edits emphasize provider neutrality

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**Medicine - End Stage Renal Disease Services**

▲ 90951 End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face physician visits by a physician or other qualified health care professional per month

Edits emphasize provider neutrality
Pulmonary Medicine Changes Overview

- New Guidelines
- Seven Code Revisions
- New Instructions on Existing Codes

Medicine - Gastroenterology
Gastroenterology

▲ 91110  Gastrointestinal tract imaging intraluminal (eg., capsule endoscopy), esophagus through ileum, with physician interpretation and report

▲ 91111  Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with physician interpretation and report

● 91112  Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report

► (For measurement of gastrointestinal tract transit times or pressure using wireless capsule, use 91112)

► (Do not report 91112 in conjunction with 83986, 91020, 91022, 91117)
OPHTHALMOLOGY
GENERAL OPHTHALMOLOGICAL SERVICES

Interpretation and report by the physician or other qualified health care professional is an integral part of special ophthalmological services where indicated. Technical procedures (which may or may not be performed by the physician personally) are often part of the service, but should not be mistaken to constitute the service itself.

(For distinguishing between new and established patients, see Evaluation and Management guidelines)

OPHTHALMOLOGY
SPECIAL OPHTHALMOLOGICAL SERVICES

92015 – Determination of refractive state

(For instrument based ocular screening, use 99174)

Rationale:
The parenthetical note instructs users to use code 99174 for instrument based ocular screening.
OPHTHALMOLOGY
SPECIAL OPHTHALMOLOGICAL SERVICES

92132 – Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
▶ (For specular microscopy and endothelial cell analysis, use 92286)▶

OPHTHALMOLOGY
OTHER SPECIALIZED SERVICES

▲ 92286 – Special anterior segment photography imaging with interpretation and report; with specular endothelial microscopy and endothelial cell count analysis

▲ 92287 – with fluorescein angiography

Terminology update and to be more general about the technology utilized for this imaging service

To disseminate RUC surveys a revision of code 92286 was needed
**OPHTHALMOLOGY**

**SPECTACLE SERVICES**

(INCLUDING PROSTHESIS FOR APHAKIA)

► Fitting

When provided, fitting of spectacles is a separate service; when provided by the physician, it and is reported as indicated by 92340-92371.

Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of the spectacles to the visual axes and anatomical topography. Presence of the physician or other qualified health care professional is not required. ◄

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CORONARY THERAPEUTIC SERVICES AND PROCEDURES

Codes 92920-92944 describe percutaneous revascularization services performed for occlusive disease of the coronary vessels (major coronary arteries, coronary artery branches, or coronary artery bypass grafts). These percutaneous coronary intervention (PCI) codes are built on progressive hierarchies with more intensive services inclusive of lesser intensive services. These PCI codes all include the work of accessing and selectively catheterizing the vessel, traversing the lesion, radiological supervision and interpretation directly related to the intervention(s) performed, closure of the arteriotomy when performed through the access sheath, and imaging performed to document completion of the intervention in addition to the intervention(s) performed. These codes include angioplasty (e.g., balloon, cutting balloon, wired balloons, cryoplasty), atherectomy (e.g., directional, rotational, laser), and stenting (e.g., balloon expandable, self-expanding, bare metal, drug eluting, covered). Each code in this family includes balloon angioplasty, when performed. Diagnostic coronary angiography may be reported separately under specific circumstances.

Diagnostic coronary angiography codes (93454-93461) and injection procedure codes (93563-93564) should not be used with percutaneous coronary revascularization services (92920-92944) to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the coronary intervention,
2. Vessel measurement for the coronary intervention, or
3. Post-coronary angioplasty/stent/atherectomy angiography, as this work is captured in the percutaneous coronary revascularization services codes (92920-92944).
Coronary Therapeutic Services and Procedures

Diagnostic angiography performed at the time of a coronary interventional procedure may be separately reportable if:

1. No prior catheter-based coronary angiography study is available, and a full diagnostic study is performed, and a decision to intervene is based on the diagnostic angiography, or

2. A prior study is available, but as documented in the medical record:
   a. The patient’s condition with respect to the clinical indication has changed since the prior study, or
   b. There is inadequate visualization of the anatomy and/or pathology, or
   c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention.

Diagnostic coronary angiography performed at a separate session from an interventional procedure is separately reportable.

New codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92920</td>
<td>Percutaneous transluminal coronary angioplasty, single major coronary artery or branch</td>
</tr>
<tr>
<td>92921</td>
<td>Each additional branch of a major coronary artery (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td></td>
<td>(Use 92921 in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943)</td>
</tr>
<tr>
<td>92924</td>
<td>Percutaneous transluminal coronary atherecetomy, with coronary angioplasty when performed; single major coronary artery or branch</td>
</tr>
<tr>
<td>92925</td>
<td>Each additional branch of a major coronary artery (List separately in addition to code for primary procedure)</td>
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<td>(Use 92925 in conjunction with 92924, 92928, 92933, 92937, 92941, 92943)</td>
</tr>
<tr>
<td>92928</td>
<td>Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch</td>
</tr>
<tr>
<td>92929</td>
<td>Each additional branch of a major coronary artery (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>
New codes

- Use 92928 in conjunction with 92926, 92931, 92941, 92944

# ©●92933 Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch

# ©●●92934 Each additional branch of a major coronary artery (List separately in addition to code for primary procedure)

- Use 92933 in conjunction with 92931, 92933, 92941, 92944

# ©●92937 Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel

# ©●●●92938 Each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)

- Use 92938 in conjunction with 92937

# ©●92941 Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel

- For additional vessels treated: see 92920-92930, 92943, 92944

---

New codes

- Use 92924 in conjunction with 92926, 92931, 92941, 92944

# ©●92943 Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel

# ©●●●92944 Each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)

- Use 92944 in conjunction with 92924, 92926, 92931, 92941, 92944

- To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use 92974

- For intravascular radioelement application, see 77785-77787

# ©●▲92973 Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure)

- Use 92973 in conjunction with 92920, 92924, 92926, 92931, 92933, 92941, 92943, 92975, 93454-93461, 93563, 93564

- Do not report 92973 for aspiration thrombectomy

# ©●92974 Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)
PCI Services—Why Change?

- CMS requested RUC examine codes 92980 and 92981 on the RUC Multi-Specialty Points of Comparison (MPC) list
- Coronary stent codes 92980 and 92981:
  - Heterogeneous set of codes which often included other therapeutic procedures
  - Did not reflect work complexity of combined procedures
- Code change proposal to restructure codes

New Coding Model

- Modeled after the lower extremity endovascular revascularization codes
  - 3 territories; each territory has 1 to 3 vessels
  - Report one major intervention in each territory, add-on codes for additional vessels in the same territory
- Coronary model
  - 5 major coronary arteries
  - Report up to two interventions in branch vessels with add-on codes
- CMS rejected this model in the coronary arteries as more granular and chose to bundle the branch vessel services into the major vessel codes
Coronary Therapeutic Services and Procedures

What Changed?
• 6 stent, angioplasty, atherectomy codes were deleted
• Created 13 new codes
• Redefined “Major Coronary Arteries”
• More specific codes for interventions—with more intensive services inclusive of less intensive services

PCI Services—Major Vessel changes
• For PCI services, definition of “major” vessel now includes LAD, left circumflex, and right coronary plus left main and ramus intermedius
• All interventions in a major vessel itself (including proximal, mid, and distal vessel) are reported with one PCI code (report the highest service level of intervention performed)
• Interventions in up to 2 branches of each major vessel may be reported with add-on codes (LAD diagonals, circumflex marginals, etc.)
PCI Services—Major Vessel Changes

- **LC** Left circumflex coronary artery
- **LD** Left anterior descending coronary artery
- **RC** Right coronary artery

<table>
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<tr>
<th>CMS Manual System</th>
<th>Department of Health &amp; Human Services (DHHS)</th>
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<td>Pub 100-20 One-Time Notification</td>
<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
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<tr>
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<td>Date: November 1, 2012</td>
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SUBJECT: National Correct Coding Initiative (NCCI) Associated Modifier Changes (Additions)

1. SUMMARY OF CHANGES: Additional modifiers shall be added to the list of NCCI-associated modifiers that will allow an edit with modifier indicator of “+” to be bypassed when the modifier is utilized correctly. These modifiers are **LM** (left main coronary artery), **RI** (ramus intermedius), 24 (unrelated evaluation and management service by the same physician during a postoperative period), and 57 (decision for surgery).

Coronary Therapeutic Services and Procedures

![Anterior View of the Heart Coronary Arteries](image)
PCI Services—New Intervention Codes

- Seven reportable interventions:
  - Balloon angioplasty (92920, +92921)
  - Stent (92928, +92929)
  - Atherectomy alone (92924, +92925)
  - Atherectomy+stent (92933, +92934)
  - Any PCI of or through a coronary bypass graft (includes distal protection) (92937, +93938)
  - Any PCI of acute/subacute occlusion during acute MI (92941)
  - Any PCI of chronic total occlusion (92943, +92944)
- All include balloon angioplasty when performed
Reporting Guidelines for Multiple Target Lesion Procedures—Base Codes

- Report only one base code for each major coronary artery approached (LAD, CFX, RCA, LM, ramus intermedius); that code reports all services in that major vessel (prox, mid, distal)
- Report, as the base code, the most intensive service performed in that major vessel system
  1. Acute total occlusion = chronic total occlusion higher than
  2. Atherectomy + stent higher than
  3. Atherectomy without stent higher than
  4. Stent higher than
  5. Any service through a bypass graft higher than
  6. Balloon angioplasty alone (based upon CMS valuations)

Reporting Guidelines for Multiple Target Lesion Procedures—Add-on Codes

- Report up to 2 add-on codes for services in branches of each major coronary artery approached; that code reports all services in that branch (prox, mid, distal)
- Services performed in more than 2 branches are not separately reportable.
- Report, as add-on code, the most intensive service(s) performed in that major vessel system
  1. Chronic total occlusion = bypass graft service higher than
  2. Atherectomy with stent higher than
  3. Atherectomy without stent higher than
  4. Stent higher than
  5. Balloon angioplasty alone (based upon RUC valuations)
Other Reporting Guidelines

• If a single lesion extends from one target vessel (major coronary artery, graft, or branch) into another target vessel but can be revascularized with a single intervention bridging the two vessels, report with a single code (eg, LAD into diagonal, LM into LAD)

• For bifurcation lesions (when both treated), report for both vessels (eg, LAD and LAD diagonal)

Guidelines for Services Performed On or Through Bypass Grafts

• Describes arterial and venous conduits, both direct (eg, LIMA) and free (eg, RIMA from aorta to RCA)
• Each separate graft represents a major coronary artery
• A sequential graft (more than one distal anastomosis) represents only one graft
• A branching graft (Y graft) represents a major vessel for the main graft (aorta to distal anastomosis) and each branch off the main graft represents an additional coronary vessel
• PCI performed on a major vessel through a graft is reported using the graft PCI codes
• When a major artery is treated both through the native circulation and through a graft, report both base codes
Acute MI Occlusions

• 92941 includes all services performed (balloon, stent, atherectomy, manual aspiration thrombectomy, distal protection) at all sites in that vessel

• Mechanical thrombectomy may be reported separately

Chronic Total Occlusions

• Chronic total occlusion is present when there is no antegrade flow through the true lumen accompanied by suggestive angiographic and clinical criteria that the occlusion has been chronic (calcification at the occlusion site, collaterals present, no ST elevation)
Thrombectomy

• Catheter aspiration thrombectomy is not separately reportable
• Mechanical thrombectomy (eg, Angiojet®) is reported separately (92973)

Reporting Diagnostic Angiography when Performed at Time of Intervention

• No prior catheter-based coronary angiography is available and a full diagnostic study is performed and decision to intervene is based upon the results OR
• A prior study is available but, as documented in the medical record, either:
  – The patient’s clinical condition (relating to the indication) has changed since the prior study); or
  – Inadequate visualization of the anatomy in the prior study; or
  – Clinical change during the procedure requiring new evaluation outside of the target area of PCI
All PCI Services Include

- Contrast injections, angiography, roadmapping, fluoroscopic guidance for the intervention;
- Vessel measurements for the interventions;
- Post-intervention angiography
- #NOTE: Codes 92920-92944 & 92973-92979 are out of numerical sequence.

Imaging Add-on Codes

- Intravascular ultrasound (+92978, +92979); report once for transducer manipulations and repositioning within the specific vessel both before and after the intervention)
- Intravascular Doppler velocity and/or pressure derived coronary flow measurement (+93571, +93572)
- Intravascular spectroscopy (0205T)
- Intravascular optical coherence tomography (0291T, 0292T)
Examples of PCI Coding—POBA

**Procedure:**
Angioplasty of LAD diagonal 1 and
Angioplasty of LAD diagonal 2

**How to Code?**

Example: Multiple Major Coronary Arteries

**Procedure:** Angioplasty of LAD, 2 LAD diagonals, RCA

**How to Code?**
Example: Hierarchical Code Structure

**Procedure:** Patient with long hazy 80% lesion in the circumflex coronary artery undergoes balloon angioplasty followed by stent placement.

**How to code?**

---

Example: Hierarchical Code Structure

**Procedure:** Patient with long calcific lesion RCA undergoes percutaneous rotational atherectomy; multiple attempts to place a stent are unsuccessful, and balloon angioplasty is performed to the region.

**How to code?**
Example: Hierarchical Code Structure

Procedure: Patient undergoes atherectomy of a heavily calcified lesion in the LAD that extends through the origin of the 1st LAD diagonal; a stent is then placed in the LAD and balloon angioplasty of the LAD diagonal is performed

How to code?

Example: Hierarchical Code Structure

Procedure: A guidewire is passed through total occlusion in the proximal LAD, initial balloon angioplasty reveals large thrombus burden with recurrent occlusion, mechanical thrombectomy is performed followed by angioplasty & stent to the proximal LAD. An additional stent placed to mid-LAD, and balloon angioplasty of large second diagonal is performed.

How to code?
Example: Hierarchical Code Structure

**Procedure:** Patient has calcified total occlusion of LAD with collaterals; lesion crossed with guidewire, then angioplasty performed followed by rotational atherectomy and stent placement

**How to code?**

New Cardiac Catheterization Guidelines

- Do not report pharmacologic administration +93463 in conjunction with PCI (92920-92944) or with coronary thrombolysis (92975, 92977)
- Injection for pulmonary angiography (+93568) may be reported with right heart catheterization codes 93451, 93453, 93456, 93457, 93460-93461, 93530-93533
- When aortography is performed with other cardiac catheterization procedures, report +93567 for supravalvular aortography and the radiological supervision and interpretation code (36221, 75600-75630) for non-supravalvular thoracic or abdominal aortography
CMS Final Rule RVU Actions

- CMS expressed an interest in pursuing further bundling in the PFS payment structure
- Concern raised that more granular coding may encourage increased placement of stents
- Bundled the work of the add-on (branch vessel) codes into the work of the major arteries

CMS Algorithm for PCI RVUs

- “. . . used the RUC-recommended utilization crosswalk to determine what percentage of the base code utilization would be billed with the add-on code;
- Added that percentage of the RUC-recommended RVUs to the RUC-recommended base code RVUs”
- CMS will have a PFS procedure status indicator of “B” (bundled code) for codes +92921, +92925, +92929, +92934, +92938, and +92944
- CMS will not pay for “additional branch” add-on codes
CMS Algorithm for PCI RVUs

So How to Code for PCIs?

• Payer policy will prevail:
  – CMS will not pay for “additional branch” add-on codes
  – CMS will have a PFS procedure status indicator of “B” (bundled code)
• Please contact other payers to determine their 2013 policy with regards to PCI codes
Cardiac Electrophysiology Ablation Procedures—Why New Codes?

• RAW screen for procedures performed together frequently (EP study generally performed prior to ablation)

• New codes better describe current procedures (atrial tract ablation, VT ablation, pulmonary vein isolation) and include the diagnostic electrophysiology study

• At times, a successful ablation procedure will reveal another arrhythmia with a different mechanism requiring an additional procedure

Cardiac Electrophysiology Ablation Procedures—Changes

• New introductory language with definitions and clarification with regard to:
  – Arrhythmia induction
  – Mapping
  – Ablation

• Guidelines for use of new codes
• Parenthetical instruction for use of new/existing codes
Cardiac Electrophysiology Ablation Procedures—Changes

- Deletion of intracardiac catheter ablation codes 93651 and 93652
- 5 new codes (93653-93657) differentiating ablation techniques for:
  - Supraventricular arrhythmias
  - Ventricular arrhythmias
  - Pulmonary vein isolation (for atrial fibrillation)
  - Ablation of discrete mechanism of arrhythmia separate from the primary ablated mechanism
  - Additional linear or focal ablation for mechanism of atrial fibrillation remaining after pulmonary vein isolation

Ablation Techniques

<table>
<thead>
<tr>
<th>New CPT Code</th>
<th>EP + Ablation Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>93653</td>
<td>• Ablation SVT (dual AV nodal pathways, accessory AV connections, other atrial foci)</td>
</tr>
<tr>
<td>93654</td>
<td>• Ablation of ventricular tachycardia or focus of ventricular ectopy</td>
</tr>
<tr>
<td>93656</td>
<td>• Ablation of atrial fibrillation - pulmonary vein electrical isolation</td>
</tr>
</tbody>
</table>
Ablation Techniques (cont.)

New CPT Code

93655

Additional ablation procedure of arrhythmia distinctly separate from primary ablated mechanism (includes repeat diagnostic maneuvers)

EP + Ablation Treatment

- Reported in conjunction with 93653 (SVT), 93654 (VT), 93656 (atrial fib)
- Not reported for treatment of another atrial fibrillation mechanism

New CPT Code

93657

Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation

EP + Ablation Treatment

- Reported in conjunction with 93656 when:
  - successful pulmonary vein isolation is achieved
  - attempts at re-induction of atrial fibrillation find another focus of atrial fibrillation
  - further ablation of the new mechanism is performed
Ablation Code Guidelines

- Ablation codes (93653-93657) include the single site and comprehensive electrophysiology study services (93600-03603, 93619, 93620)
- Atrial fibrillation ablation (93656) includes pacing and recording from the coronary sinus (93621) when performed.
- Trans-septal puncture (93462) may be reported separately for ablations except for atrial fibrillation ablation (93656, 93657) which includes trans-septal puncture
- 93653, 93654, and 93656 are distinct primary services and may not be reported together

Ablation Code Guidelines—Mapping

- Mapping is a distinct procedure and may be reported separately with atrial ablation procedures
- VT ablation (93654) includes mapping
- Do not report standard mapping (93609) in addition to 3-D mapping (93613)—only one or the other
Ablation Code Guidelines

Which add-on code (93655 or 93657) should be reported if a successful pulmonary vein isolation procedure for atrial fibrillation reveals a second, independent mechanism?

• Report +93655 when an additional non-atrial fibrillation tachycardia mechanism is identified after atrial fib ablation
• Report +93657 when an additional left or right atrial focus for atrial fibrillation is identified after successful pulmonary vein isolation

Bundling EPS with Transcatheter Ablation

• New Bundled Code: SVT EP study with ablation
  – 93653 RVUs = 15.00
• Previously Reported
  – 93651(16.23) + 93620 (11.57/2*) = 22.02

• New Bundled Code: Atrial fib EP study with ablation
  – 93656 RVUs = 20.02
• Previously Reported
  – 93651(16.23) + 93620 (11.57/2*) = 22.02

*Multiple Procedure Reduction Rule Applies
Bundling EPS with Transcatheter Ablation

• New Add-on Code for Additional non-AF Atrial Focus
  – 93655 RVUs = 7.50
  – Not previously reported

• New Add-on Code Additional Atrial Fib Focus
  – 93657 RVUs = 7.50
  – Not previously Reported

*Multiple Procedure Reduction Rule Applies

Bundling EPS with Transcatheter Ablation

• New Bundled Code: VT EP study with ablation
  – 93654 RVUs = 20.00
  • Previously Reported
    – 93652 (17.65) + 93620 (11.57/2*) = 23.44

• New Add-on Code for Additional VT Focus
  – 93655 RVUs = 7.50
  – Not previously reported

*Multiple Procedure Reduction Rule Applies
CMS Final Rule Payment Policy Issues

- Many diagnostic cardiology services now subject to the MPPR (affects only technical component)
  - Nuclear cardiology imaging
  - ECG, stress test, rhythm strip, event monitor, ambulatory cardiac telemetry
  - Pacer and ICD evaluations, programming
  - Echocardiography (TTE & TEE)
  - Vascular studies

Ventilator Management
Changes to Existing Code

94005  Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more

(Do not report 94005 in conjunction with 99339, 99340, 99374-99378)

► (Ventilator management care plan oversight is reported separately from home or domiciliary, rest home [eg, assisted living] services. A physician or other qualified health care professional may report 94005, when performed, including when a different individual* reports 99339, 99340, 99374-99378 for the same 30 days)

*individual = provider group!
Pulmonary Diagnostic Testing and Therapies
New Guidelines

► Codes 94010-94799 include laboratory procedure(s) and interpretation of test results. If a separate identifiable Evaluation and Management service is performed, the appropriate E/M service code including new or established patient office or other outpatient services (99201-99215), office or other outpatient consultations (99241-99245), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), and home services (99341-99350), may be reported in addition to 94010-94799.

Pulmonary Diagnostic Testing and Therapies
Revised Codes

▲ 94014 Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation and by a physician review or other qualified health care professional.

▲ 94016 physician review and interpretation only by a physician or other qualified health care professional.
Pulmonary Diagnostic Testing and Therapies Revised Codes

▲ 94452 High altitude simulation test (HAST), with physician interpretation and report by a physician or other qualified health care professional;
(For obtaining arterial blood gases, use 36600)
(Do not report 94452 in conjunction with 94453, 94760, 94761)

▲ 94453 with supplemental oxygen titration
(For obtaining arterial blood gases, use 36600)
(Do not report 94453 in conjunction with 94452, 94760, 94761)

Pulmonary Diagnostic Testing and Therapies Revised Codes

宍▲ 94610 Intrapulmonary surfactant administration by a physician or other qualified health care professional through endotracheal tube
(Do not report 94610 in conjunction with 99468-99472)
(For endotracheal intubation, use 31500)
(Report 94610 once per dosing episode)
Pulmonary Diagnostic Testing and Therapies Revised Codes

▲94774 Pediatric home apnea monitoring event recording including respiratory rate, pattern and heart rate per 30-day period of time; includes monitor attachment, download of data, physician review, interpretation, and preparation of a report by a physician or other qualified health care professional

▲94777 physician review, interpretation and preparation of report only by a physician or other qualified health care professional (When oxygen saturation monitoring is used in addition to heart rate and respiratory monitoring, it is not reported separately)

(Do not report 94774-94777 in conjunction with 93224-93272)
(Do not report apnea recording device separately)
(For sleep study, see 95805-95811)

Non-Physician Diagnostic Testing: Performing vs. Supervising For Medicare

Performing Diagnostics
– May perform and interpret
– No physician supervision
– Inpatient/facility issues
  • Credentialing
  • Privileges
  • JCAHO/other regulatory limits

Supervising Diagnostics
– Diagnostic testing a different benefit category!!!
– Cannot supervise another NPP or resident, since cannot fulfill the physician supervision (general, direct or personal) requirement for the diagnostic testing benefit!!!

…and remember screening is yet still a different defined benefit category!!!
94770  Carbon dioxide, expired gas determination by infrared analyzer;

► (For bronchoscopy, see 31622-31646)

► (For thoracentesis, use 32554, 32555)
Allergy and Clinical Immunology

Allergy Testing

Ingestion Challenge Testing

Allergen Immunotherapy

Revised Guideline

▶ Other therapy: for medical conferences on the use of mechanical and electronic devices (precipitators, air conditioners, air filters, humidifiers, dehumidifiers), climatotherapy, physical therapy, occupational and recreational therapy, see Evaluation and Management section services.

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Revised Guideline

- Do not report Evaluation and Management (E/M) services for test interpretation and report. If a significant separately identifiable E/M service is performed, the appropriate E/M service code, which may include new or established patient office or other outpatient services (99201-99215), hospital observation services (99217-99220, 99224-99226), hospital care (99221-99223, 99231-99233), consultations (99241-99255), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), home services (99341-99350), preventive medicine services (99381-99429) should be reported using modifier 25. 

• Rationale:
  – Explicit code listing provide greater specificity and transparency
  – Provides accurate representation of the services in the appropriate sites of service
  – Code range description is provided to eliminate the need for constant cross-referencing

• Example:
  – Hospital observation services (99217-99220, 99224-99226)
Allergy Testing

• Revised parenthetical
  
  (For administration of medications [e.g., epinephrine, steroidal agents, antihistamines] for therapy for severe or intractable allergic disease/reaction, see 96365-96369, use 96372, 96374, 96375)

• Rationale:
  – Specific instructions for administration of medications
  – Include examples of types of medications administered

Allergy Testing-Venom or Drug - Background

• 2011 CMS requests review of 95010 and 95015 as potentially Misvalued thru low value-billed in multiple units screen
  – Work of percutaneous and intradermal testing not significantly different per RUC – codes billed together >80% of time - allergy directed to merge codes
  – Found costs of antigens (venom versus Pre-Pen) substantially different
Typical Patient

- **Venom**
  - 42 year old with history of insect sting followed by generalized urticaria and mild chest discomfort – requires venom allergy testing

- **Drug (typical drug Penicillin)**
  - 48 y/o with chronic sinusitis and history of multiple antibiotic adverse reactions

- **Pre-service work** — updated history and exam – consent – verify equipment present

Test Protocol

- **Venom**
  - Typical patient undergoes 27 tests – sequential groups of 5 tests plus one set of positive and negative controls

- **Drug (Penicillin)** — 2 sequential groups
  - Group 1 – 4 percutaneous tests including 2 controls
  - Group 2 – 4 intradermal tests + one negative control
Allergy Testing Cont.

► (95010 and 95015 have been deleted. To report, see 95017 and 95018)◄

Deleted Code

95010

Percutaneous tests (scratch, puncture, prick) - sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests.

Deleted Code

95015

Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests.

Allergy Testing Cont.

► (95010 and 95015 have been deleted. To report, see 95017 and 95018)◄

New Code

● 95017

Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests.

New Code

● 95018

Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests.
Allergy Testing Cont.

• Rationale
  – Deleted 95010 and 95015
  – Added 95017 and 95018
  – New testing procedure utilizes venoms or drugs/biologicals rather than differentiating primarily based on the technique used
  – A new parenthetical cross-reference has also been added
    – 95017 work RVU = 0.07
    – 95018 work RVU = 0.14

Ingestion Challenge Testing - Background

• Previous code 95075
• The Joint Council of Allergy & Immunology (JCAAI) determined work was based on review by a specialty who is not current dominant provider
• JCAAI applied to CPT for 2 new codes
  – Initial 120 minutes (typical represents negative test)
  – Add-on to report additional increments of 60 minutes to more accurately describe range of time and work involved
Compelling Evidence

- Food allergy incidence >10 million
  - 3 million children
- Prevalence under 18 increased 18% between 1997 and 2007
  - Recent study found higher prevalence than previously reported – 8% under 18 (95% CI)
  - Same study – 38.7% had severe reaction
  - 30.4% had multiple allergies

Compelling Evidence (cont)

- 1995 RUC review – typical patient wheat allergic with nasal congestion symptoms
- Typical patient today – peanut allergic with reported symptoms of anaphylaxis and death
  - Not typical but death and anaphylaxis during testing is serious concern and requires close monitoring by physician
- 2003-2006 ~317,000 ED visits for food allergy
- Currently ~125,000 ED visits annually for food allergy – 12.5% with anaphylaxis - >100 deaths annually
Compelling Evidence (cont)

- 1995 work described as intermittent assessment for one hour after ingestion of ½ dose of wheat, then if no reaction another ¼ dose administered – if no reaction – test negative

- 2012 – 5 test peanut doses over 2 hours starting with touching lips with first dose – followed by increments up to total 2 teaspoons

Pre-Service Work

- 1994 Medicare data
  – Allergy 41% allergy, 32% otolaryngology
- 2010 Medicare data
  – 90.9% allergy, 0.65% otolaryngology
- Pre-service work – updated history – vital signs – pertinent labs reviewed
- Intra-service work – physician available in office for entire intra-service period
Typical Patient

• 95076 – 8 year old with history of acute allergic reaction to peanut at age 2 – monitored by serial allergy skin and serum tests – no additional known peanut exposures – patient undergoes ingestion challenge to determine if peanut allergy resolved

Typical Patient (cont)

• 95079 – 8 year old with history of allergic reaction to peanut at age 2 – monitored by serial skin and serum tests – no additional known exposure to peanut – ingestion challenge to determine if peanut allergy resolved
  – First 120 minutes reported separately 95076
  – Has a potential reaction (hives, angioedema, wheezing) requiring extended testing and additional testing is performed – monitoring continues until patient clinically stable
Ingestion Challenge Testing

► (95075 has been deleted. For ingestion challenge testing, see 95076, 95079)◄

► Codes 95076 and 95079 are used to report ingestion challenge testing. Report 95076 for initial 120 minutes of testing time (ie, not physician face-to-face time). Report 95079 for each additional 60 minutes of testing time (ie, not physician face-to-face time). For total testing time less than 61 minutes (eg, positive challenge resulting in cessation of testing), report Evaluation and Management service, if appropriate. Patient assessment/monitoring activities for allergic reaction (eg, blood pressure testing, peak flow meter testing) are not separately reported. Intervention therapy (eg, injection of steroid or epinephrine) may be reported separately as appropriate. ◄

► For purposes of reporting testing times, if an evaluation and management service is required, then testing time ends. ◄

Ingestion Challenge Testing Cont.

► (95075 has been deleted. For ingestion challenge testing, see 95076, 95079)◄

Deleted Code

95075

Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite);
Ingestion Challenge Testing Cont.

New Code

95076

Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing

New Code

95079

each additional 60 minutes of testing (List separately in addition to code for primary procedure)

► (Use 95079 in conjunction with 95076) ◄

Ingestion Challenge Testing Cont.

• **Rationale:**
  – Deleted 95075
  – Added new section heading
  – Added 95076 and 95079 as a time-based service
  – Added new guidelines, deletion cross-reference & a note to provide clear instructions
    – 95076 work RVU = 1.50
    – 95079 work RVU = 1.38
New Sleep Medicine Testing Guidelines

► All sleep services (95800-95811) include recording, interpretation and report. (Report with modifier 52 if less than 6 hours of recording for 95800, 95801, 95806, 95807, 95810, 95811; if less than 7 hours of recording for 95782, 95783 or if less than four nap opportunities are recorded for 95805).
Revised Sleep Medicine Testing Codes

▲95808  Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist

▲95810  age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

▲95811  age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

New Pediatric Sleep Medicine Testing Codes

#●95782  younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

#●95783  younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist
New Pediatric Sleep Medicine Testing Codes

Why higher valuation than for adults?
Children sleep longer than adults (9 vs. 8 hrs)
More hypopneas than apneas
More movement artifacts
Extra channels (eg, breath CO₂)
Typically 1:1 technician:child ratio

CPT Code (●New) Work RVU

<table>
<thead>
<tr>
<th>CPT Code (●New)</th>
<th>Work RVU</th>
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</thead>
<tbody>
<tr>
<td>#●95782</td>
<td>2.60</td>
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<tr>
<td>#●95783</td>
<td>2.83</td>
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</table>

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Nerve Conduction Tests

- 95900-95904 deleted, seven new codes
- Guidelines revised to define single conduction study:
  - Sensory
  - Motor with or without F wave
  - H-reflex
- Each type of study reported 1x for multiple sites on same nerve.
- Appendix J revised – let’s look at page 652 in your CPT, then page 371-372 in your Changes book!
Appendix J

Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves

This summary assigns each sensory, motor, and mixed nerve with its appropriate nerve conduction study code in order to enhance accurate reporting of codes 95907-95913. Each nerve constitutes one unit of service.

Motor Nerves Assigned to Codes 95900 and 95907-95913

1. Upper extremity, cervical plexus, and brachial plexus motor nerves
   A. Axillary motor nerve to the deltoide
   B. Long thoracic motor nerve to the serratus
   C. Radial motor nerve to the extensor carpi ulnaris
   D. Median nerve to the thumb and index fingers
   E. Median nerve to the long finger
   F. Median nerve to the short finger
   G. Median nerve to the ring finger
   H. Ulnar nerve
      1. Ulnar motor nerve to the abductor digiti minimi
      2. Ulnar motor nerve to the palmar interosseous
      3. Ulnar motor nerve to the first dorsal interosseous
      4. Ulnar motor nerve to the flexor carpi ulnaris
   I. Other
   II. Lower extremity motor nerves
      A. Femoral motor nerve to the quadriceps
         1. Femoral motor nerve to vastus medialis
         2. Femoral motor nerve to vastus lateralis
         3. Femoral motor nerve to vastus intermedius
         4. Femoral motor nerve to rectus femoris
      B. Ilioinguinal nerve
      C. Peroneal (fibular) nerve
         1. Peroneal motor nerve to the extensor digitorum brevis
         2. Peroneal motor nerve to the peroneus brevis
         3. Peroneal motor nerve to the peroneus longus
         4. Peroneal motor nerve to the tibialis anterior
      D. Obturator motor nerve

Nerve Conduction Tests

• Restructured to reflect number of studies performed, rather than each nerve, as the unit of service.

- 95907  Nerve conduction studies; 1-2 studies
- 95908  3-4 studies
- 95909  5-6 studies
- 95910  7-8 studies
- 95911  9-10 studies
- 95912  11-12 studies
- 95913  13 or more studies
### Nerve Conduction Tests

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>2012</th>
<th>2013</th>
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</thead>
<tbody>
<tr>
<td>95900</td>
<td>Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study</td>
<td></td>
<td>95907 Nerve conduction studies; 1-2 studies</td>
</tr>
<tr>
<td>95903</td>
<td>motor, with F-wave study</td>
<td></td>
<td>95908 3-4 studies</td>
</tr>
<tr>
<td>95904</td>
<td>sensory</td>
<td></td>
<td>95909 5-6 studies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>95910 7-8 studies</td>
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<td></td>
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<td>95911 9-10 studies</td>
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<td></td>
<td>95912 11-12 studies</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>95913 13 or more studies</td>
</tr>
</tbody>
</table>

- Parenthetical notes in Electromyography section revised to reflect changes to nerve conduction study codes.
- H-reflex codes 95934, 95936 *deleted*
  - H-reflex now reported new codes 95907-95913.
Nerve Conduction Tests – example (use appx J)

Typical peripheral neuropathy patient with numbness of both feet
- Unilateral radial sensory nerve
- Unilateral sural sensory nerve
- Unilateral peroneal motor nerve recording from extensor digitorum brevis with f
- Unilateral tibial motor nerve with f

Needle EMG: abductor hallucis, tibialis anterior, medial gastrocnemius.*

* If above are abnormal, then vastus lateralis, gluteus medius, gluteus minimus

Nerve Conduction Tests – example (use appx J)

Typical L5 radiculopathy patient with shooting pain spiraling down the leg to big toe
- Unilateral sural sensory nerve
- Unilateral peroneal motor nerve recording from extensor digitorum brevis with f
- Unilateral tibial motor nerve with f
- Sometimes, bilateral superficial peroneal sensory nerve

Needle EMG: tibialis anterior, medial gastrocnemius, vastus lateralis, gluteus medius, gluteus minimus*#

* Sometimes tibialis posterior
# Sometimes lumbosacral paraspinal muscles to look for active denervation

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Nerve Conduction Tests – example (use appx J)

Typical Carpal Tunnel Syndrome patient with nocturnal right hand numbness

- Bilateral median nerve motor nerve without f, two point stimulation
- Unilateral ulnar motor nerve without f, two point stimulation
- Bilateral median nerve sensory
- Unilateral ulnar nerve sensory
- Unilateral median nerve midpalmar mixed
- Unilateral ulnar nerve midpalmar mixed

Needle EMG: deltoid, triceps, extensor digitorum communis, flexor carpi radialis, abductor pollicis brevis, first dorsal interossei

Intraoperative Neurophysiology

- Code 95920 deleted
- Codes 95940, 95941 added

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>+95920</td>
<td>IONM testing, per hour</td>
<td>+95940 Continuous IONM in the OR, one on one monitoring requiring personal attendance, each 15 minutes</td>
</tr>
<tr>
<td>+95940</td>
<td>Continuous IONM in the OR (remote or nearby) or for monitoring of &gt;1 case while in the OR, per hour</td>
<td></td>
</tr>
</tbody>
</table>
Intraoperative Neurophysiology

- Guidelines added
  - Continuous monitoring, testing and interpretation
  - Not reported by operating surgeon or anesthesiologist
  - Immediate communication directly with OR team required
  - Not for devices not requiring continuous or one-on-one monitoring.
  - 95940 – present in OR, for one case only, monitoring charge by 15 minute increment (i.e. 8-22 minutes)
  - 95941 – outside the OR, more than one case, monitoring charge per hour increment (i.e. 31-90 minutes).

CMS IONM

- CMS will not pay for CPT code 95941, but created G code to divide into 15 minute increments.

- Concern:
  - 1 practitioner billing individual patients for monitoring >1 patient for the same work during the same time interval
  - Created HCPCS G0453: Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)
  - effective January 1, 2013.
Federal Register excerpt

- CPT code 95941 directs 1 or more simultaneous cases may be reported - report 95941 for all remote or non-1-to-1 monitoring time connected to each case regardless of overlap with other cases.

- (CMS) We are concerned that CPT code 95941 allows a practitioner to bill individual beneficiaries for monitoring more than one beneficiary for the same work during the same time interval.

- To resolve this, we created HCPCS G0453 (Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)), effective January 1, 2013.

Federal Register excerpt

- G0453 may be billed only for *undivided* attention by the monitoring physician to 1 patient
  - Cannot be used for simultaneous attention by the monitoring physician to more than one patient.

- HCPCS G0453 may be billed in multiple units to account for the cumulative time spent monitoring, that is, 15 minutes of continuous attendance followed by another 15 minutes later in the procedure would constitute one half hour of monitoring (G0453 w/unit of 2)

- HCPCS G0453 replaces CPT code 95941
  - CPT 95941 = status indicator of I (Not valid for Medicare)
  - CPT 95940 = status indicator A (Active for Medicare)
Autonomic Function Tests

• Two new codes added
  – 95924 – combined parasympathetic and sympathetic adrenergic testing with passive tilt
  – 95943 – simultaneous, independent, quantitative measures of parasympathetic function and sympathetic function

• New Guidelines added
  – Provide instruction on proper reporting of the codes
  – Required components for reporting 95921 and 95922

• Exclusionary parenthetical notes

• RUC review as part of the screens:
  – Codes Reported Together 75% or More
  – Different Performing Specialty from Survey

Category III, Motor Function Mapping

• New code 0310T
  – Navigated transcranial magnetic stimulation (nTMS)
  – Localizes functional motor cortex for neurosurgical pre-op planning
  – Uses TMS and EMG guided by standard MRI data
  – Not reported with EMG codes 95860-95870, or evoked potential study codes 95928, 95929, 95939

0310T Motor function mapping using non-invasive navigated transcranial magnetic stimulation (nTMS) for therapeutic treatment planning, upper and lower extremity

(Do not report 0310T in conjunction with 95860-95870, 95928, 95929, 95939)
Medical Nutrition Therapy

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
(Physicians and other qualified health care professionals who may report evaluation and management services should use the appropriate Evaluation and Management codes)

Exception to CPT neutrality

Acupuncture – Guideline Revision

Evaluation and Management services may be reported in addition to acupuncture procedures when performed by physicians or other health care professionals who may report evaluation and management services. Evaluation and Management Service codes, including new or established patient office or other outpatient services (99201-99215), hospital observation care (99217-99220, 99223-99225), hospital care (99221-99223, 99231-99233), office or other outpatient consultations (99241-99245), inpatient consultations (99251-99255), critical care services (99291, 99292), inpatient neonatal intensive care services and pediatric and neonatal critical care services (99466-99480), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), and home services (99341-99350), may be reported separately; using modifier 25; if the patient's condition requires a significant, separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the acupuncture services. The time of the E/M service is not included in the time of the acupuncture service.
Multiple QHP References

Guideline Revisions

- Reference to “other qualified healthcare professional” has been added to reflect neutrality within both of these sections

Special Services, Procedures and Reports - Revisions

▲99000 Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory

▲99001 Handling and/or conveyance of specimen for transfer from the patient in other than the physician's office to a laboratory (distance may be indicated)

▲99002 Handling, conveyance, ...by the attending physician or other qualified health care professional

(For physician standby services requiring prolonged physician attendance, use 99360, as appropriate. Time spent performing separately reportable procedure(s) or service(s) should not be included in the time reported as mandated on-call service)

▲99070 Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above ...
Special Services, Procedures and Reports - Revisions

▲99071 Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient’s education at cost to physician or other qualified health care professional

▲99078 Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)
(For physician/or other qualified health care professional qualified by education, training, licensure/regulation [when applicable] collection and interpretation of physiologic data stored/transmitted by patient/caregiver, see 99091)

▲99091 Collection and interpretation of physiologic data ......to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable), requiring a minimum of 30 minutes of time
Category II - Summary

- Category II codes are optional for providers to report. They are not reimbursed however are used for quality reporting.
- New and revised clinical conditions are spread throughout this section with 2013 reflecting 5 new code additions.

Category III – Temporary Codes

Services/procedures described in this section make use of alphanumeric characters. These codes have an alpha character as the 5th character in the string, preceded by four digits. The digits are not intended to reflect the placement of the code in the Category I section of CPT nomenclature. Codes in this section may or may not eventually receive a Category I CPT code. In either case, in general, a given Category III code will be archived five years from the date of initial publication or extension unless a modification of the archival date is specifically noted at the time of a revision or change to a code (e.g., addition of parenthetical instructions, reinstatement). Services/procedures described by Category III codes, which have been archived after five years, without conversion, must be reported using the Category I unlisted code unless another specific cross reference is established at the time of archiving. New codes in this section are released semi-annually via the AMA/CPT internet site, to expedite dissemination for reporting. The full set of temporary codes for emerging technology, services, and procedures are published annually in the CPT codebook. Go to www.ama-assn.org/go cpt for the most current listing.
Appendices

Appendix A - Modifiers

► 24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health care Professional During a Postoperative Period: The physician or other qualified health care professional may need to indicate...

► 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health care Professional on the Same Day of the Procedure or Other Service: It may be necessary to indicate that one the …

► 26 Professional Component: Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.
Appendix A - Modifiers

►51 Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual provider, the primary procedure or service may be reported as listed……►

Modifiers 52, 53, 54, 55, 56, 58, 62, 63, 66, 76, 77, 78, 79 are also changed with information regarding individual or other qualified health care provider. See Appendix A for full descriptors.

Edits emphasize CPT neutrality

Appendix I – Genetic Testing Code Modifiers (Deleted)

The Genetic Testing Code Modifiers (formerly Appendix I) has been removed from the CPT codebook. The addition of more than 100 molecular pathology codes to the 2012 code set and still more codes to the 2013 CPT code set has resulted in the deletion of the molecular laboratory procedures related to genetic testing. The genetic testing code modifiers applied to those codes, and therefore, the modifiers are no longer applicable to the 2013 code set.
Appendix J - Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves

In support of the changes to the Nerve Conduction Tests section, Appendix J was revised to reflect the deletion of codes 95900-95904 and the addition of codes 95907-95913.

- This summary assigns each sensory, motor, and mixed nerve with its appropriate nerve conduction study code in order to enhance accurate reporting of codes 95907-95913. Each nerve constitutes one unit of service.

Appendix O - MAAA

Multianalyte Assays with Algorithmic Analyses (MAAA)

The 2013 CPT code set contains a new Administrative Code List (Appendix O). Appendix O contains 3 new Administrative and 9 new Category I Multianalyte Assays with Algorithmic Analyses (MAAA) codes. Also included are introductory guidelines that provide specific guidance on how to accurately report or assign codes and the specific requirements for inclusion in the Administrative Code List or as a Category I code. Codes 81508 and 81599 were inadvertently left out of Appendix O. This correction will be included in the 2013 CPT errata document and posted on the AMA CPT Web site (www.ama-assn.org/ama/pub/physicianresources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/errata.page).
Common CMS Claim Issues
from Contractor Medical Directors (CMD)

CMS Claims/Coding Issues

• Claim reviews and denial rates
  – Vertebroplasty/Kyphoplasty
  – Facet Blocks
• Mohs Surgery
Claims/Coding Issues

• Assistant at surgery modifier (AS-NPP as assistant at surgery)
  – Qualified NPP (PA, NP and enrolled in Medicare)

Claims/Coding Issues

• Billing the services of a surgical assistant (surgical technician, first surgical assistant, scrub nurse, etc.) that is ‘not qualified’ as ‘incident to’ the performing physician is not a Medicare covered service
CMS Claims/Coding Issues

- Assistant at surgery modifier (AS- NPP as surg. assistant)
  - Procedure (0 indicator – paid if documentation supports medical necessity) (1-may not be paid; 2- may be paid)

CMS Claims/Coding Issues

- Multiple joint injections, with every single one “requiring ultrasound guidance”
- Injections billed as blocks, joint injections, etc which really are trigger point injections.
CMS Claims/Coding Issues

• Use of modifier -59 for imaging with those procedures that now *include* imaging in the code description and payment e.g.:
  – Paravertebral joint/nerve blocks
  – Transforaminal epidurals
  – Many others

CMS Claims/Coding Issues

• Using records software to “document” and claim for:
  – A service that was not performed
  – A service that was not necessary
CMS Claims/Coding Issues

–Time is generally a “secondary” criterion
–Becomes “primary” when “counseling &/or coordination of care” > 50 %
  • Care needed to document the necessity
  • Times in this use is an absolute minimum threshold (“rounding up” not allowed!)

CMS Claims/Coding Issues

• In calculating time for E&M:
  – “Non face-to-face” time is generally not included
    • Instead is usually pre or post-service
    • Caution with family discussion time: to be included in total time only when the family member is a necessary surrogate for the patient! (otherwise is pre and post-service)
CMS Claims/Coding Issues

• Critical care
  – Only one during a specified period of time
  – Contractor rules on Initial vs. Subsequent
  – But all require first provider billing to him or herself meet the threshold time requirement
  – Must be evident documented necessity

• Global Surgical package
  • Includes H&P as well as post-op follow-up to extent of global period
  • Longstanding issues with pre-procedure “consults”
  • Special review focus now (several areas)
    – Regular H&P being performed by hospitalists
    – Global Post-op services planned as provided by another with no “54/55 split”
CMS Claims/Coding Issues

“INCIDENT TO”

A) An initial physician has seen the patient
   This is the physician to whom the subsequent service(s) may be “incident”

B) Pt. subsequently seen by ARNP, PA, CNS acting within scope of license for same problem
   If a new problem (or new patient) the service cannot be “incident to”

C) “Incident to” “Supervising” physician –
   - Must be present & immediately avail to assist
   - In whose name the service is billed
   - **May** be the physician to whom services incident

D) Physician to whom the service is incident must retain involvement with this patient for this problem (see contractor for specific rules)
CMS Claims Coding Issues

Advanced Beneficiary Notice “ABN”

• This was newly revised in 2011
• Must use the exact format!
• MLN Article:

CMS Claims Issues

Recovery Audit Contractors (a.k.a. “Recovery Auditors” or RAs)

• RACs are paid on contingency basis – but only net recoveries
• Same five levels of appeals – USE THEM!!
CMS Claims Issues
Recovery Auditors

• Non-participating physicians still subject to RAC audits for assigned claims
• Watch specialty societies & the RAC websites!!

CMS Claims Issues
Locate LCDs

• http://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs.html

CMS Claims Issues

ZPIC

• Zone Program Integrity Contractors
• Replacing the Program Safeguard Contractors (PSCs) & Medicare Drug Integrity Contractors (MEDICs)
• One Integrity Contractor for all Medicare claims for a geographic area
• Focus: “Fraud & Abuse”
  – If receive request: treat seriously!

Assistance with a ZPIC audit:

http://www.zpicaudit.com/tag/zpic/
Thank you!
Save the Date!
ICD-10-CM Workshops
The American Medical Association will host more ICD-10-CM workshops in 2013. Additional information will be posted on the following Web site as it becomes available:
ama-assn.org/go/icd10workshops

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