CPT Update 2008

Audio Seminar/ Webinar

December 6, 2007

Practical Tools for Seminar Learning

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Ms. Brown is a Senior Manager at DCBA, Inc. She has over twenty-five years of experience in Health Information Management (HIM) covering hospital outpatient, inpatient, surgical centers, physician office, clinic, consulting, law firms, and third-party areas. Her hands-on experience covers a wide range of HIM issues in a variety of settings. Ms. Brown’s areas of expertise include coding, DRGs & APCs, education, audits, compliance, ensuring optimal reimbursement, operational assessments, and process re-design. She has been a consultant and seminar instructor through the Southern Medical Association (SMA) and Medical Group Management Association (MGMA) as well as other consulting companies. Ms. Brown has been a speaker for AHIMA, FHIMA, THIMA, the VA, and numerous associations. Previous positions include Director of Coding, Compliance, and Education with McStrategies and PhyCor, Coding and Reimbursement Specialist with large multi-specialty clinics, and VISN 8 Compliance and Business Integrity Specialist with the VA. Ms. Brown is part of the DCBA, Inc team with Dr. Robert S. Gold.

Ms. Brown is a graduate of the University of Central Florida with a Bachelor of Science degree in Health Information Management. She holds three of the four national coding designations. Ms. Brown is active in and continues to support many professional and civic organizations, including the American Health Information Management Association (AHIMA), Florida Health Information Management Association (FHIMA), Tennessee Health Information Management Association (THIMA), and the American Academy of Professional Coders (AAPC).

Karen Scott, MEd, RHIA, CCS-P, CPC

Karen Scott is credentialed as a Registered Health Information Administrator with twenty years of experience in the healthcare field. She has earned the Certified Coding Specialist, Physician Based (CCS-P) and the Certified Professional Coder (CPC) Credentials from AHIMA and AAPC.

Karen is the owner of Karen Scott Seminars and Consulting. She has been an educator for many years including teaching in the Health Information Management Programs at the University of Tennessee Health Science Center and Arkansas Tech University. She has worked as an HIM director in an acute care hospital setting, training director for a national transcription company, and reimbursement specialist for a regional physician’s group. She holds a Bachelor of Science Degree in Health Information Management and a Master’s Degree of Education in Instructional Technology from Arkansas Tech University in Russellville, Arkansas. She is past-president of both the Tennessee and Arkansas Health Information Management Associations and is past-chair of the AHIMA Council on Certification. Karen has won several awards including the Tennessee Innovator Award. In 2005, THIMA recognized Karen for her achievements with their Distinguished Member Award.

Karen teaches seminars on coding, reimbursement, medical terminology and management throughout the country for physician and hospital audiences. She has published numerous articles on various healthcare topics including writing several chapters in HIM and Coding textbooks. Her textbook, *Coding and Reimbursement for Hospital Inpatient Services*, published by AHIMA, was released in February 2006 and her new AHIMA book *Medical Coding for the NonCoder*, will be released in the fall.
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Objectives of this Seminar

- Introduction and Overview of the CPT code changes for 2008
- Summarize changes by chapter
  - E/M, modifiers, and surgical
  - Handouts include: radiology, path, lab, and medicine

Change Statistics

- Per the AMA, the CPT code set for 2008 includes:
  - 8,661 codes
    - 244 new codes
    - 314 revised codes
    - 52 deleted codes
    - Refer to next table from the AMA
  - Close numbers - Approximation
  - Refer to Appendix B - summary of additions, deletions, and revisions
### General Changes

- There were many changes made across the entire book.
  - Section, sub-section, headings
  - Results, testing, interpretation, and report
    - These instructions have been “moved” to the Introduction section - Instructions for Use of the CPT book, (from the individual sections)
Modifiers and Appendices

- Defined modifiers
- Service performed has been “altered by some specific circumstance but not changed in definition or code”
  - Allows response to payment policy requirements and specifications
  - Revised descriptions of commonly used modifiers to clarify intent

More General Changes

- Modifier 51
  - Development of new exempt criteria by the CPT editorial panel with RUC information
  - Refer to Appendix E
  - Also refer to Appendix D - add-on codes
  - Deletion of the symbol “Θ” is indicated by inclusion of a revision symbol “▲” on the revised codes for modifier 51 exempt status
New Modifier 92

- Alt Lab Platform Testing
  - Single use kit/ transportable instrument
  - Use with HIV testing codes only
    - 86701-86703

 Appendix E, Modifier 51 Exempt

- Criteria established to allow codes to be on exempt list
  - Procedure typically performed with another procedure but not add on because could be performed independently
  - Not on CMS multiple procedure reduction list
  - Minimal amount of pre- and post- service time
  - No add on codes selected
  - Payments shouldn’t be reduced when performed with another procedure
  - Performed with many other procedures so impractical to list all if on add on list

- Many codes removed from list
E/M Changes - 99xxx

- **Code changes:**
  - Added 12
  - Deleted 5
  - Revised 9

- New subheadings
- Revision of subheadings
- Guideline revisions
  - Critical care
    - Procedural inclusions

E/M Section Changes - 99xxx

- **New subsections for:**
  - Medical team conferences - with new codes 99366-99368
    - Case management codes 99361-99362, deleted, now reported with new codes
  - Non face-to-face physicians services
    - with new codes 99441-99443, 99444 for:
      - Telephone services - 3 previous codes deleted
      - On line medical exam
Medical Team Conference - 993xx

- 3 new codes 99366-99368
  - Deleted from 99361-99362
  - Physician and Non-physician
  - Pt/ family present and not present
  - New guidelines present

Requirements
- By a minimum of three qualified health care professionals
- From different specialties/ disciplines
- Must be actively treating the patient and within the the past 60 days
- Only one person per specialty/ discipline may report
- Must be documented
Medical Team Conference - 993xx - Time

- Time Requirements
  - 30 min or more
  - Time starts when the conference starts, then ends
  - Time not counted outside the conference
    - Report writing
  - If <30 minutes, physicians may report their time spent in a team conference with the patient and/or family present using evaluation and management (E/M) codes based on time.

Medical Team Conference - 993xx - Face-to Face?

- Code - 99366 face-to-face by non-physician
- No code for the physician - code E/M based on time
  - Count only face-to-face time
- Without patient or family - 2 codes
  - 99367 - physician
  - 99368 - non-physician
  - Can use for Tumor Board IF all requirements are met
Telephone Services - 994XX

- 3 levels - time based in minutes
  - 99441 - 5-10 minutes
  - 99442 - 11-20 minutes
  - 99443 - 21-30 minutes

- Requirements:
  - Must be patient or guardian of patient “initiated”
  - Must be an established patient
  - Cannot code if:
    - leading to an E/M visit/service in the next 24 hrs or next available appointment time
    - is related to E/M performed within previous 7 days
    - is within the post-op period - global

On-Line Medical Services - 994xx

- Physician - 99444, non-physician - 98969
- Similar to telephone services - 7 day window before and after
- “Reported only once for the same episode of care during a 7-day period”
- “Sum of communication” related to the on-line patient encounter
- Established patient or guardian of patient “initiated”
- May be reported if E/M results from the on-line exam - (different than telephone)
- Note - do not “double dip”
- Refer to guidelines explained
  - Timely, storage, global
Behavior Change Interventions - 994xx

- Revision of subheadings:
  - Counseling risk factor reduction and behavior change intervention
    - Guideline explanation
  - Behavior change interventions, individual includes new time-based codes 99406-99409 for:
    - Alcohol/other substance abuse screening and intervention services
      - >3 min - up to 10 min.
      - Intensive - >10 min.
    - Smoking cessation counseling
      - 15-30 min
      - >30 min

Neonatal and Pediatric E/M Section Changes - 992xx

- Revision of subheadings:
  - Inpatient neonatal and pediatric critical care and intensive service - 99293-99296
    - Guidelines for “not critically ill”
    - Inclusive procedures
    - New code - 99477 for neonate, initial day, for “intensive observation, …” listed under Other E/M service
    - This code has a cross reference under initial hospital care.
**E/M Section Changes - 99xxx**

- Revision of codes for:
  - The majority were from the Nursing facility care section
    - Codes: 99304-99310, 99318
    - Addition of the time element
  - One code for subsequent inpatient neonatal critical care - 99296

**Anesthesia Section Changes - 019xx**

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- Revision of TIPS procedure - 01931 to include shunt(s)
- Spine and spinal cord - percutaneous image guided procedures, replaced the deleted - 01905 code:
  - 01935 - diagnostic
  - 01936 - therapeutic
Integumentary Section Changes - 1xxxx

- Guideline revision
  - For more “grammatical clarification”
    - “Chemical destruction” added to removal of skin tags
  - Clarify intent
    - Excision and adjacent tissue transfer

2 codes revised
- 11008 - expanded description to include “chronic or recurrent mesh infection”, (in addition to necrotizing soft tissue infection) for removal of prosthetic material or mesh, for infection
  - Used in hernia repairs
- 17110 - expanded to include “proliferative” up to 14 lesions - destruction of benign lesions other than skin tags of cutaneous proliferative lesions
Musculoskeletal Section Changes - 2xxxx

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- Largest group of changes within the surgical section
- Guideline revision and instruction changes or additions throughout chapter
- Revision of many codes for modifier 51 exempt changes
  - deletion of the modifier 51 exempt status symbol “✓” is indicated by inclusion of a revision symbol “▲” on the revised codes.

Revision of many codes clarifying external fixation is reported separately, when performed in addition to the listed procedures

▲ 26615 Open treatment of metacarpal fracture, single, with or without includes internal or external fixation, when performed, each bone
**MS Radioelement Application - 2055x**

- New code - 20555 to report placement of needles or catheters into muscle and/or soft tissue interstitial radioelement application.
  - At the time of or subsequent to the procedure
  - Cross-references notes added for other specific organ sites and for imaging guidance
  - Always performed in the OR
  - Anticipation of brachytherapy for soft tissue sarcomas

**MS Computer Navigation - 209xx**

- 3 add-on codes 20985-20987 for computer navigation for musculoskeletal procedures:
  - Codes are differentiated by generation of an image
    - 85 - lack of (20985)
    - 86 - pre-op
    - 87 - intra-operative
  - Codes 20986-20987 note indicating these codes are reported once even if multiple imaging modalities are used.
  - Previously reported with category III codes 0054T-0056T - now deleted
**TMJ Manipulation - 210xx**

- New code - 21073
- Manipulation TMJ joint(s), *therapeutic*, *requiring anesthesia*
  - Instruction note for without anesthesia, see other codes: 97140, 98925-9, and 98943.
  - For closed treatment, see 21480, 21485

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**MS Vertebral Osteotomy - 222xx**

- 3 new osteotomy of spine codes 22206-22208 for posterior or posteriolateral, three-columns, one vertebral segment
  - 22206 - thoracic
  - 22207 - lumbar
  - 22208 - add-on code for each additional vertebral segment; reported with 22206-22207
- 3 columns =
  - Anterior = anterior 2/3rds of the vb-(vertebral body)
  - Middle = posterior 3rd of the vb & pedicle
  - Posterior = articular facets, lamina, & spinous process
- New guidelines and notes were added.
- Report instrumentation and bone graft in addition...
**MS Spinal Section Changes - 22xxx**

- Many notes throughout section including spinal instrumentation and bone grafting to be coded in addition to primary procedure.

- Arthrodesis cross reference notes are present to code in addition, when applicable.

**MS Tenotomy Elbow - 243xx**

- 3 new codes 24357-24359 for tenotomy, elbow, lateral or medial
  - 24357 - percutaneous
  - 24358 - debridement, soft tissue, open
  - 24359 - same, but open with tendon repair or reattachment
- Old faciotomy codes 24350-24352, 24354, 24356 deleted with notation referring to new codes
- Provides simpler description for treatment of epicondylitis
**MS Posterior Malleolus Fracture - 277xx**

- 3 new codes 27767-27769 for posterior malleolus fracture repair
  - 27767 - closed without manipulation
  - 27768 - same with manipulation
  - 27769 - open including internal fixation when performed
- Notes present precluding separate reporting with bi or trimalleolar ankle fracture treatments

**MS Arthroscopy - 298xx**

- New code 29828 for biceps tendon arthroscopy, surgical, shoulder
- Revision of code 29866 arthroscopy, knee, osteochondral autograft to include note to refer to open procedure
- New codes for subtalar joint 29904-29907
**MS Subtalar Joint - 299xx**

- New codes 29904-29907 - arthroscopic procedures of the subtalar joint
  - “Subtalar procedures are intended to report procedures of the joint between the talus and the calcaneus.”
- For other arthroscopic ankle procedures to address synovectomy, debridement, and arthodesis of the tibiotalar and fibulotalar joints, report codes 29894-29899.

**Respiratory Changes - 3xxxx**

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- Lungs and Pleura 324xx
  - Deleted codes and renumbered (new codes)
  - Rearranged to make more sense
  - Removal
  - Thoracentesis
    - 32421 with pleural puncture for aspiration initial or subsequent
    - 32422 with tube insertion including water seal when done
      - Pneumothorax
      - Separate procedure, do not report note
      - Can code image guidance separately
**Introduction and Destruction - 325xx**

- New (from the deleted) codes:
  - **32550** Indwelling tunneled pleural catheter with cuff
  - **32551** Tube thoracostomy
    - Includes water seal for abscess, hemothorax, empyema
    - Separate procedure, do not report note
    - Code image guidance separately if performed
  - **32560** Chemical pleurodesis
    - For recurrent or persistent pneumothorax

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**Cardiovascular Changes - 3xxxx**

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- **332xx** Electrophysiologic Operative Procedures
  - Note to describe procedures and rewriting of procedures because of three new add on codes for maze procedure
  - Includes tissue ablation, disruption and reconstruction to treat supraventricular dysrhythmias
  - Laser, cold, microwave, ultrasound, radiofrequency, incision
  - Excision/isolation of left atrial appendage done with atrial tissue and ablation procedures is included
  - May need to use add on codes with open cardiac procedures
Incision - Ablation - 332xx

- New add-on codes 33257-33259 for Maze procedure:
  - Operative tissue ablation and reconstruction of atria, at the time of other cardiac procedures
    - 33257 - Limited
    - Extensive - 33258-33259
      - With (33259) or without (33258) cardiopulmonary bypass
  - List of codes to use with...
- Revised note for 33256 Operative tissue ablation and reconstruction

Combined Arterial-Venous Grafting for Coronary Bypass - 335xx

- Revised codes 33517-33523 for add on status
- Removed from list of modifier 51 exempt codes
- Changed:
  - from, list separately in addition to code for arterial graft
  - to, list separately in addition to code for primary procedure
- Also notes underneath codes to signify which codes to use with (codes for arterial grafts)
Thoracic Aortic Aneurysm - 338xx

- 33864 New code for Ascending aorta graft with cardiopulmonary bypass
  - Aortic Root reconstruction to preserve aortic valve
  - New technology where valve does not have to be replaced
    - With valve suspension, coronary reconstruction and valve sparing aortic annulus remodeling
      - David Procedure
      - Yacoub Procedure
    - Do not report note

Endovascular Repair of Abdominal Aortic Aneurysm - 348xx

- 34806 Transcatheter placement of wireless physiologic sensor in aneurysmal sac during repair (endovascular)
  - Endovascular Aneurysm Repair (EVAR)
  - Implantable Wireless Pressure Sensor (IWPS)
  - Was in Category III section
  - Includes radiology S&I, calibration of instrument, pressure data collection
  - Completely noninvasive, no radiation, no contrast used
    - Add on code
  - Code for analysis in medicine section
**Bypass Graft - 35xxx**

- **Vein**
  - **35523** New code for brachial-ulnar or - radial
  - Bypass around blockage in arm
    - Chronic Arterial Occlusive Disease
      - Upper extremity limb ischemia
  - Notes underneath code

- **Other than Vein**
  - **35600** Revised code for harvest of upper extremity artery
  - Add on code, use with codes for CABG

**Venous Access Procedures - 365xx**

- Revised heading - “Other Central Venous Access Procedures”
- **36591-36593** New codes for blood collection and declotting using thrombolytic agent
  - Can use for any line including PICC line, peripheral IV
  - Instruction notes included
Transcatheter Procedures - 371xx

- 37184 Arterial Mechanical Thrombectomy
  - New notes to explain use of codes
  - Changed some of the wording
    - “treatment of” to “the retrieval of short segments of”
      - Additional work to remove thrombus
    - “complicating” to “evident during”
      - Codes shouldn’t be used for piecemeal removal of thrombus during other procedures

More on Transcatheter Procedures

- Can be primary with thrombosis diagnosis
  - Do primary first to determine need for other procedures such as angioplasty, stenting, thrombolysis
- Secondary is done with another percutaneous intervention
  - “rescue” thrombectomy
    - Original intent is to fix something else
- Pretreatment for mechanical thrombectomy
- Per vascular family
- Initial code and one code for all secondary within same family
- Different family through separate access
- Watch do not report notes
Lymph Nodes - 387xx

- 1 Revised code:
  - 38792 Injection for id of sentinel node
  - Revised code to remove modifier 51 exempt symbol

Digestive System Changes - 4xxxx

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- 41019 New code for placement of needles or other devices in head/neck for subsequent interstitial radioelement application
  - Typically following removal of mouth/tongue tissue for cancer (squamous cell)
  - Can be percutaneous, transoral or transnasal
  - Code also imaging
  - Not for stereotactic insertion of brachytherapy sources
Introduction - 437xx

- Deleted percutaneous gastrostomy tube code
- Notes to refer coder to correct new codes
- Naso or orogastric tube placement
- 43760 Change of gastro tube without imaging or endoscopic guidance
- 43761 Repositioning of gastric feeding tube
  - Removed “any method”

Bariatric Surgery - 437xx

- Laparoscopy notes
- Follow up care for adjustable gastric restrictive procedures includes subsequent adjustment(s) throughout post op period
  - Changing diameter by injecting fluid through port
- 43770-43774 Revised codes changed from gastric band to gastric restrictive device
  - To avoid use of trademarked name
**Enterostomy - 443xx**

- **44300** Revised code for placement of an enterostomy or cecostomy, tube *OPEN* (e.g. FOR FEEDING or decompression)

**Abdomen Excision, Destruction - 49xxx**

- **New codes**
  - Typically used when primary organs have previously been removed, now going back in (open procedure) to remove tumors
  - Uterus, tubes, ovaries
  - **49203** Open excision or destruction of intra-abdominal tumors, cysts or endometriomas one or more
    - Peritoneal, mesenteric or retroperitoneal
    - Primary or secondary tumors
    - Largest 5 cm diameter or less
  - **49204** Largest 5.1-10.0 cm diameter
  - **49205** Largest greater than 10.0 cm diameter
**Tube Initial Placement - 494xx**

- New codes for Percutaneous insertion of tubes
  - NG or OG tube included and not coded separately
  - Under fluoro guidance
  - Includes contract injection(s), image doc and report
    - 49440 Gastrostomy
    - 49441 Duodenostomy/ jejunostomy
    - 49442 Cecostomy/ other colonic tube
  - Note: Routine change of G-tube without fluoro is still coded to 43760

**Tube Conversion or Replacement - 494xx**

- New codes and instructions for:
  - Conversion – 49446 Gastro tube to gastro-jejunostomy tube
    - Note for conversion at time of initial placement, use two codes
  - Initial placement tube: for existing tube removal, with new tube placed through new site, this is not a replacement - use:
    - 49450 Gastrostomy or cecostomy
    - 49451 Duodenostomy or jejunostomy
    - 49452 Gastro-jejunostomy
**Mechanical Removal Obstructive Material - 494xx**

- New heading and new code **49460**
  Gastrostomy, Duodenostomy, jejunostomy, gastro-jejunostomy, cecostomy/other colon tube
  - Any method
  - Under fluoro with contrast injection(s) if done
  - Don’t use with replacement codes

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**Other - 494xx**

- **49465** New code for contrast injection(s) for radiological evaluation of existing stomy tube
  - Percutaneous approach
  - Includes image documentation, report
  - Do not use with replacement codes or mechanical removal of obstructive matter
**Mesh with Hernia Repair - 495xx**

- **49568** Revised description for implantation of mesh or other prosthesis with incisional/ventral hernia repair
  - Added “or mesh” for closure of debridement for necrotizing soft tissue infection
  - New instructional note under code to show which codes can use this one with
    - Usage note includes 11004-6 as well as incisional/ventral hernia repair codes

**Urinary System Changes - 5xxxx**

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- New codes **50385-50386** for internally dwelling ureteral stent
  - Removal - **50385**
  - Removal and replacement - **50386**
  - Transurethral approach, snare/capture
    - Not using cystoscopy
    - Includes usage of radiology S&I
    - Moderate sedation included
**Urinary System Changes - 5xxxx**

- Other procedures - 505xx:
- New code 50593 Renal tumor(s) ablation percutaneous, using cryotherapy
  - Unilateral
  - Code imaging separately
  - Was a Category III code

![Urinary System Diagram]

**Bladder - 510xx**

- Incision codes deleted and renumbered
- New Heading Removal
- Bladder aspiration 51100-51102
  - Needle
  - Trochar, intracatheter
  - With insertion of suprapubic catheter
- Code imaging separately
**Urodynamics - 517xx**

- Revised code 51797 Voiding pressure studies
  - Intra-abdominal voiding pressure
  - Made it an add on procedure to use with main code
  - Tx urinary incontinence, retention, frequency
  - Additional calculations recorded

**Prostate - 524xx**

- New code 52649 Laser enucleation of prostate with morcellation
  - Laser used to remove small portions of prostate
  - Includes control of bleeding
  - Complete
  - Watch do not report notes
Male Genital - 5xxxx

- **Epididymis 54700 and Scrotum 55100**
  - Notes for debridement of necrotizing soft tissue infection
  - External genitalia
  - Use codes in skin section under debridement

Reproductive System Procedures - 559xx

- New heading
- 1 New code 55920
- Placement needles/ catheters into pelvic organs/ genitalia
- Prostate coded elsewhere
- For application of radioelement
- Watch notes for placement in other organs
### Female Genital - 5xxxx

- **Added**: 6
- **Deleted**: 2
- **Revised**
  - Note to instruct how to code excision/destruction of endometriomas
  - Vagina repair revised code 57284
    - Paravaginal defect repair (including repair of cystocele,
      - Removed “stress urinary incontinence and/or incomplete vaginal prolapse because code now used only for cystocele, if repaired
      - Added if performed; open abdominal approach”
    - Added new code for vaginal approach 57285

### Vagina Endoscopy - 574xx

- **New code**: 57423 paravaginal defect repair, laparoscopic approach
  - Repair of cystocele is included if done
  - Do not report notes
- **Revised code Excision 57500**
  - Cervical biopsy or local excision of lesion, with/without fulguration
  - Separate procedure
  - Added “of cervix” to specify site
Laparoscopy/ Hysteroscopy - 585xx

- Lots of do not report notes throughout section
- New surgical laparoscopy codes 58570-58573
- Total Hysterectomy
- Uterus 250 g or less/ greater than 250 g
- With removal of tubes/ ovaries

Endocrine System - 60xxx

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- Deleted code 60001
- Replaced with new heading
- Removal (because it is not an excision)
- Aspiration/ injection of cyst of thyroid 60300
- Code image guidance separately
- Do not use this code for fine needle aspiration
**Nervous System - 6xxxx**

<table>
<thead>
<tr>
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<th>Revised</th>
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</tbody>
</table>

- **Neurorrhaphy 648xx**
  - Revised codes, 64834-64836 Suture of one nerve;
    - hand or foot, Common sensory nerve
    - Median motor thenar
    - Ulnar motor
  - In parent code, semicolon was after hand or foot
    - In revised code, semicolon is before hand or foot
  - The secondary codes involve nerves in the upper limbs, not the foot

**Eye Procedures - 6xxxx**

<table>
<thead>
<tr>
<th>Added</th>
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</table>

- **Anterior Chamber 658xx**
- **New headings 659xx**
  - Removal
  - Introduction
- **Anterior Sclera 66170**
  - Note under trabeculectomy
  - Dilation of Schlemm’s Canal with/without retention of device use Category III Codes
**Lens - 66xxx**

- **New Headings -**
  - Removal 66830-66940
  - Intraocular Lens Procedures 66982-66986
    - Cataract codes
  - Other procedures 66990, 66999
    - Use of endoscope (add on code)
    - Long list of do not report with...

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**Posterior Segment - 670xxx**

- **Vitrectomy new codes (one code subdivided into three) 67041-67043**
  - With removal of preretinal cellular membrane such as macular pucker
    - Removes cellular membrane from center of retina (macula)
  - With removal of internal limiting membrane of retina
    - For example repairing macular hole, diabetic macular edema
    - Includes intraocular tamponade with air, gas, silicone oil
Posterior Segment - 670xx

- With removal of sub retinal membrane such as choroidal neovascularization
  - Includes intraocular tamponade with air, gas, silicone oil
  - And laser photocoagulation
    - For proliferative vitreoretinopathy or diabetic traction causing retinal detachment
- Code also use of ophth endoscope
- Code also vitrectomy in retinal detachment surgery

Repair Retina or Choroid - 671xx

- New code 67113 Complex retinal detachment repair
  - Proliferative vitreoretinopathy, stage C-1 or greater
  - Diabetic traction retinal detachment
  - Retinopathy of prematurity
  - Retinal tear > 90 degrees
  - With vitrectomy and membrane peeling
  - May include air, gas, silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage subretinal fluid, scleral buckling, and/or lens removal
**Prophylaxis - 67xxx**

- Treatment during one or more sessions, may be different encounters
- Report once during “defined treatment period”
  - Revised codes and new code 67227-67229
    - Tx retinopathy, extensive/progressive, one/more sessions
      - 67229 Preterm infant <37 weeks gestation at birth
      - Performed from birth to age 1
      - Photocoagulation or cryotherapy
    - Use -50 for bilateral procedure

**Lacrimal System - 68xxx**

- *68816 New Code: Probing of nasolacrimal duct*
  - With dilation of transluminal balloon catheter
    - Into tear ducts, removes obstruction
  - Unilateral procedure
  - Don’t use with other probing codes
References

- *CPT 2008 Professional Edition, American Medical Association*
- *CPT 2008 Changes; An Insider’s View, AMA*
- *2008 CPT Coding Symposium*

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- *This seminar material is informational only. Appropriate codes used for billing purposes should be selected according to documentation in the patient’s legal health record.*

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Addendum A

More information on:

- Radiology
- Path-Lab
- Medicine
- Category codes

Radiology - 7xxxx

- Revised CTA codes starting at 70496, 70498
- Reworded from “without contrast followed by... and further sections”
- Added in with contrast including “noncontrast images, if performed” and image postprocessing
- Original intent not to require noncontrast imaging, just included if performed
Heart - 755xx

- Cardiac magnetic imaging different from MRI
- Includes eval of cardiac function, flow and velocity of valves and shunts with function/morphological eval
- Use additional codes for pharmaco wall motion stress eval (like stress echo) with/without contrast
- New codes for Cardiac MRI 75557-75564
  - Without contrast
  - Without contrast followed by contrast and further sequences

Transcatheter Procedures - 75xxx

- Revised code 75984
  - Change of perc tube/drainage catheter with contrast
- Other Procedures
  - Watch do not report notes
Diagnostic Ultrasound - 76xxx

- Use both color and spectral Doppler, can code both
- Doppler alone with real time ultrasound is not separately reportable
- Revised code 76506
  • Removed reference to B Scan (outdated term)

Stereotactic Radiation Treatment - 77xxx

- Revised codes 77371-77372, 77432
  • Changed from Cerebral to cranial
Nuclear Medicine, Nervous System - 78xxx

- Brain imaging revised to remove terms of limited, complete; changed to number of static views
- Other procedures PET scans 78811-78816
- Used to say tumor imaging, changed to PET imaging

Path Lab Section - 8xxxx

- New Panel code 80047
  - Basic Metabolic Panel
    - Ionized calcium
- Revised 80048
  - Basic Metabolic Panel
    - Total calcium
- Note under comprehensive metabolic panel, 80053
  - don’t use with basic metabolic panels or hepatic function panel
Chemistry - 82xxx

- Blood occult (guaiac) 272
  - Took out “single specimen (e.g., From digital rectal exam)”
  - Added in “1-3 simultaneous determinations performed for other than colorectal neoplasm screening”
- New Code for Cystatin C 610
  - Measure of renal function
    - May be more reliable than creatinine

Molecular Diagnostics - 83xxx

- Revised codes 83898-83901
- Amplification, added TARGET
  - Removed of patient nucleic acid
  - Added beyond two
- New code for Calprotectin, fecal 83993
  - Indicator for inflammatory bowel disease
  - Pediatric abdominal pain
  - Helps to determine if child needs further testing such as endoscopes/colonoscopes
  - Detects inflammation throughout whole GI tract
**Gonadotropin - 84xxx**

- New code 704 Gonadotropin, chorionic free beta chain
  - Used for screening for Down syndrome
  - Trisomy 18
  - Neural Tube Defects

**Immunology - 86xxx**

- New code 86356 Mononuclear cell antigen, quantitative—flow cytometry
  - NOS, each antigen
  - Watch do not report notes
  - Skin test; each unlisted antigen 86486
Transfusion Medicine - 86xxx

- Antihuman globulin test 86885-86886
  - Indirect qualitative each (removed antiserum), added REAGENT RED CELL
  - Indirect (removed titer, antiserum) each, added ANTI BODY TITER

Microbiology - 87xxx

- Infectious agent antigen detection 87260
- Added note of explanation
  - Intended for primary source only
  - Use most specific code possible
  - Use separate codes when separate reports for different species/strains of organisms
**Microbiology - 87xxx**

- **87500** - New code for vancomycin resistance, amplified probe technique
  - Very toxic, not used routinely
  - Common UTIs, wound infections, endocarditis, bacteremia, meningitis
  - Vancomycin-resistant enterococcus associated UTI
    - Back pain, burning during urination, frequency, diarrhea, weakness, fever and chills
- **87809** Adenovirus

**Surgical Pathology - 883xx**

- Microdissection laser capture **88380**
- Manual **88381**
- Don’t use the two codes together
Reproductive Medicine Procedures  
- 89xxx

- Semen analysis revised and new codes 89320-89331
- Volume, count, motility and differential
- Sperm presence and motility of sperm
- Volume, count, motility and differential
  - Using strict morphologic criteria (Kruger)
- Sperm eval for retrograde ejaculation, urine

Medicine - 9xxxx

- Immune Globulins and Vaccines
- Revised to show removal from modifier 51 exemption
- Note added above Immune globulins and instructions in vaccines to show they are exempt from mod. 51
Vaccines, Toxoids - 90xxx

• Age descriptions
  • Note to refer to FDA approved age recommendations on medication rather than assume from code descriptions
• Added “individual” to descriptions
  • 90656, 90658, 90700, 90702, 90714, 90715, 90718, 90732

New Vaccine Codes - 90xxx

• 90661 new code cell culture derived influenza vaccine
  • not made in chicken eggs
• 90662 enhanced immunogenicity influenza vaccine
  • Elderly population and patients where immune responsiveness is less than normal
• 90663 pandemic formulation influenza vaccine
• All have lightening bolt symbol to show FDA pending
Vaccines, Toxoids - 907xx

- Hydration, therapeutic, prophylactic and DX Injection, Infusions
- Codes designed mostly for facilities, shouldn’t be used by physician for professional fee billing in facility
- Hierarchy designed for facility
  - Chemo
  - Therapeutic
  - Hydration

Hydration - 907xx

- Revised 90760
  - Up to 1 hour changed to 31 minutes to 1 hour
  - Don’t report 30 minutes or less
- Add on rules for 90761 revised to include usage with other codes
**Therapeutic Injections and Infusions - 907xx**

- Revised add on code instructions to clarify intent
- **New codes 90769**
  - Subq infusion initial up to one hour
    - Includes pump set up and establishing site(s) for infusion
  - **90770 each additional hour**
  - **90771 additional pump setup, new infusion site(s)**
  - *Use 90770 and 90771 only once per encounter*
  - For infusion of substances into subq tissues only
    - Immune globulin replacement therapy subq (SCIg)
    - Avoid side effects of IV therapy (IVIg) such as headache, vomiting, dehydration

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**Therapeutic Injections - 907xx**

- New add on code **90776**
  - Each additional IV push of same substance
    - Don't report within 30 minutes of same pushed substance
    - Reported by facilities only
Special Ophthalmologic Services - 920xx

- Revised 92135
  - Added in *posterior segment*
    - To be more specific and separate from Category III code 081T for imaging of anterior segment

Cardiovascular Cardiography - 930xx

- Guidelines added for instruction on how to use codes
  - Use only when specific order for EKG/rhythm strip with documentation
    - Separate signed written report required
  - 1-3 lead ECG continuous monitoring not separately reported
Cardiac Procedures Removal from Modifier 51 - 9xxxx

- Codes procedures removed from modifier 51 exempt list
- Cardiac cath and injection codes - 935xx
- Intracardiac Electrophysiological Procedures/Studies 936xx

Visceral and Penile Vascular Studies - 939xx

- New code 93982
  - Noninvasive study implanted wireless pressure sensor in aneurysmal sac
  - Used to be Cat III code
  - Done at 6 months or year interval after implantation
Allergy Testing - 950xx

- Revised codes 95004, 95024, 95027
- Physician interpretation and report is included, can’t bill separately

Neurostimulators Analysis-Programming - 959xx

- Revised instructional notes to provide description of new codes
- Simple: affecting three or less
- Complex: affecting more than three of
  - Pulse amplitude, pulse duration, pulse frequency, 8 or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs or channels, alternating electrode polarities, dose time, more than one clinical feature such as rigidity, dyskinesia, tremor
New Analysis Codes - 959xx

- **95980-95982**
  - Analysis of pulse generator system; intraoperative with programming
  - Subsequent with/without programming

CNS Assessments/Testing - 961xx

- **96101 and 96118** added administering test to the patient
  - To show that physician is administering test vs. technician or computer
  - Time based codes
- **New code 96125**
  - Standardized cognitive performance testing, per hour
    - Typically for pts recovering from stroke or brain injury
      - To see what effect has had on orientation, memory, high level language function
Chemotherapy Administration - 964xx

- Revised notes as infusions
  - Not reported by physician in facility
  - Hierarchy of reporting for initial codes
  - Use also for non-cancer drugs that require more work and higher risk than for other infusions such as, but not all inclusive
    - Monoclonal antibody agents
    - Biologic response modifiers
  - Note to base code selection on work/service provided and not just by drug classification

Non-Face-to-Face Nonphysician Services - 989xx

- New heading and subheadings created to show changes in technology and communication with patients
- Use for Non-physicians only
- Telephone Services 98966-98968
  - Assessment and Management of Established patient
    - Do not use if decision to see patient within 24 hours/next available urgent appt.
    - Part of “pre-service” workup
  - Or refers to service within past 7 days/during postop period
  - 5-10 minutes, 11-20 minutes, 21-30 minutes of medical discussion
On-line Medical Evaluation - 989xx

- **98969** Using Internet resources in response to patient inquiry
  - Includes personal timely response
  - Permanent storage of encounter
  - Use once per seven-day period of time
  - Don’t use if within 7 days of visit or during post-op period

Moderate Sedation - 991xx

- Revised codes to show removal from modifier 51 exempt list
Other Services and Procedures - 991xx

• New code 99174
  • Ocular photoscreening with interp and report, bilateral
  • Was a Category III code
    • Screen for esotropia, exotropia, anisometropia, cataracts, ptosis, hyperopia, myopia

Medication Therapy Management Services - 996xx

• Face-to-face assessment/ intervention by pharmacist performed at request of patient (not routine services)
• MTMS requires:
  • Review of pt history
  • Medication profile
  • Recommendations for improving health outcomes/ treatment compliance
  • 99605-99606
    • Initial 15 minutes, new pt
    • Initial 15 minutes, established pt
    • Each additional 15 minutes
Category II Codes - xxxxF

- New modifier 8P
  - Reporting modifier, not performed NOS
- Patient Management 050xF
  - Plan of Care
    - Hemodialysis
    - Peritoneal dialysis
    - Urinary incontinence

Areas of Revision

- Patient History 1xxxF
- Physical Exam 20xxF
- Dx/Screening 3xxxF
- Therapeutic, Preventive, Other Interventions 4xxxF
- Follow up/Other Outcomes 50xxF
- Patient Safety 60xxF
Category III Codes

- Reminder that placement of code has no bearing on where it fits into Category I codes
  - May never become Category I codes
  - Codes released twice per year
  - www.ama-assn.org/go/cpt

Revised Cat III Codes xxxxT

- 0068-70T Removed add on instructions
- 0087T Added Sperm and Test, removed Assay
- 0145- 0151T CT heart procedure
  - Revised to align with radiology procedures revisions
  - not to require noncontrast imaging, just included if performed
New Category III Codes - 0171T-0183T

- Insertion of spinous process distraction device
- Monitor intraocular pressure during vitrectomy (add on code)
- CAD for chest x-rays, concurrent or remote
- Transluminal dilation of aqueous outflow canal
  - With/without device/stent retention
- EKG, 64 leads or more
- Corneal hysteresis determination
- High dose electronic brachytherapy
- Ultrasound for wound assessment
Appendix

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