DECEMBER - SPECIAL EDITION

IMM Insight

The IMM Newsletter

VEI

Indianapolis Medical Management

7330 Shadeland Station, Ste 200
Indianapolis, IN 46256

SPECIAL EDITION

In This Special Edition :

- ***CMS ELIMINATION OF CONSULTATION CODES***
- **UPDATED INFORMATION REGARDING HOLDING OF CLAIMS FOR SERVICES PAID UNDER THE 2010 MEDICARE PHYSICIAN FEE SCHEDULE**
- ***2010 CPT UPDATES***

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CMS Elimination of Consultation Codes

FINAL INSTRUCTIONS RELEASED

Pub. 100-04 Transmittal 1875

SUBJECT: Revisions to Consultation Services Payment Policy
EFFECTIVE DATE: January 1, 2010

IMPLEMENTATION DATE: January 4, 2010 It's official! Effective January 1, 2010, consultation codes will no longer be recognized by Medicare Part B, except for the telehealth consultation G-codes. Here's how the change could affect you:

Outpatient setting	Bill the appropriate **new or established patient visit code** (CPT codes 99201 – 99215), depending on the relationship status between the physician and the patient.
Inpatient setting	All providers who perform an initial evaluation and management service may now bill **initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306).**
	The **admitting or attending physician** who oversees the patient's care should use **modifier –AI,** for "Principal Physician of Record," with the initial hospital code to distinguish them from other physicians who may be providing specialty care. All other physicians who perform an initial evaluation on this patient should bill the appropriate hospital E/M code with no modifier.
Emergency Room	If the ED physician requests that another physician evaluate a patient, **both physicians** should bill **an emergency department visit code**. If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.
Medicare Primary	Check with the secondary payer on their policy regarding consultative services. It may be appropriate to re-code the claim to a consultation code before submitting the secondary claim. If the secondary payer requires recoding, practices should: • Develop a process to identify the claims in need of recoding. • Talk with your system vendor about how to change the code without changing the price on the original charge prior to submitting the claim to the secondary. • Develop a process to identify and appeal any secondary claims denied where the CPT code on the EOB does not match the CPT code submitted for secondary insurance payment.
Medicare Secondary	If the primary payer for the service continues to recognize consultation codes and the patient has Medicare secondary, physicians and others billing for these services can use appropriate visit codes or consultation codes when billing the primary payer. If a practice chooses to bill visit codes, Medicare will appropriately process the secondary claim; however, if a practice chooses the consultation codes, Medicare will deny the secondary claim. Medicare will allow you to submit a code to a private plan using the consultation codes and then re-code the claim using a visit code before submitting the secondary claim to Medicare.

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CMS ELIMINATION OF CONSULTATION CODES (continued)…

NOTE: Medicare Advantage plans are not required to follow these guidelines. Please check with each Medicare Advantage plan for instructions on billing for consultations.

*Disclaimer: Updated information from CMS and NGS is being received daily. This document is not intended to replace official CMS guidelines and only represents what was known at the time of publication on 12/17/09. It is subject to change at any time. For additional information, please refer to Transmittal 1875, Change Request 6740, issued on December 14, 2009 or MLN Matters article MM6740 "**Revisions to Consultation Services Payment Policy"** found at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf*

Additional Resource: IMM has been given permission by Dr. Peter Jenson, CPC from E/M University to provide a link (see below) to a helpful 7-minute video explaining the changes.

ATTENTIONMEDICARE IS ELIMINATING CONSULTS starting on January 1, 2010. Click HERE to watch a 7-minute video about these changes.

IMM Insight: Based on the information currently available, IMM recommends the following steps be followed when billing for consultation services.

PRIMARY INSURANCE	SECONDARY INSURANCE			
	None	Medicaid	Commercial	Medicare
Medicare	Outpatient: 99201-99215 Inpatient: 99221-99223 or 99231-99233	Outpatient: 99201-99215 Inpatient: 99221-99223 or 99231-99233	Outpatient: 99201-99215 Inpatient: 99221-99223 or 99231-99233	N/A
Medicare Advantage Plans	Contact each plan and find out if they will continue to accept consult codes (Humana will not)	Contact each plan and find out if they will continue to accept consult codes (Humana will not)	Contact each plan and find out if they will continue to accept consult codes (Humana will not)	N/A
Medicaid	Use consult codes 99241-99255, when appropriate	N/A	N/A	N/A

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CMS Elimination of Consult Codes (continued)…

Commercial Payers	Use consult codes 99241-99255, when appropriate, unless notified otherwise by payer	Use consult codes 99241-99255, when appropriate, unless notified otherwise by payer	Use consult codes 99241-99255, when appropriate, unless notified otherwise by payer	Use consult codes with primary payer, when appropriate, and write off balance as an "MSP" contractual adjustment for tracking purposes **---OR---** Use consult codes for primary insurance, when appropriate; re-code and bill balance to Medicare with appropriate E&M code for payment consideration

* * * *

Updated Information Regarding Holding of Claims for Services Paid Under the 2010 Medicare Physician Fee Schedule

This is a clarification to the listserv message that was issued on December 21, 2009. The President has signed the Department of Defense Appropriations Act of 2010 which provides for a zero percent (0%) update to the 2010 Medicare Physician Fee Schedule for a two month period, January 1, 2010 through February 28, 2010.

The Centers for Medicare & Medicaid Services (CMS) is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of claims for physicians, non-physician practitioners, and other providers of services paid under the Medicare physician fee schedule, beginning January 1, 2010. In this regard, CMS has instructed its contractors to hold claims for services paid under the Medicare Physician Fee Schedule (MPFS) for up to the first 10 business days of January (January 1 through

January 15) for 2010 dates of service. This should have minimum impact on provider cash flow because, by law, clean electronic
claims are not paid any sooner than 14 calendar days (29 days for paper claims) after the date of receipt. Meanwhile, all claims for services delivered on or before December 31, 2009, will be processed and paid under normal procedures.

The holding of claims allows Medicare contractors time to receive the new, updated payment files and perform necessary testing before paying claims at the new rates. CMS has instructed contractors to begin processing claims at the new rates **no later than** January 19, 2010. Please note that most contractors are closed on the January 18 Martin Luther King Day holiday. Therefore, even absent a new update, most claims likely would not have been paid any sooner than January 19, 2010, given the aforementioned

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UPDATED INFORMATION REGARDING HOLDING OF CLAIMS (CONTINUED)…

statutory 14-day payment floor.

CMS has extended the 2010 Annual Participation Enrollment Program end date from January 31, 2010, to **March 17, 2010**– therefore, the enrollment period now runs from November 13, 2009, through March 17, 2010.

The effective date for any Participation status change during the extension, however, remains January 1, 2010, and will be in force for the entire year.

Contractors will accept and process any Participation elections or withdrawals, made during the extended enrollment period that are received or post-marked on or before March 17, 2010.

In addition, be on the alert for more information about other legislative provisions which may affect you.

* * * *

2010 CPT UPDATES

It is recommended that **Appendix B Summary of Additions, Deletions, and Revisions** be reviewed in preparation for reporting in 2010. Appendix B will show the actual changes that were made to the code descriptors in an abbreviated format. While this report will focus on new codes and coding principals for 2010, it is not all inclusive.

2010 Resequencing Principles

The American Medical Association (AMA) was running out of numbers for new CPT codes and was forced to introduce a new numbering scheme. Twenty seven (27) codes were resequenced for 2010 and can be readily identified by looking at **Appendix N Summary of Resequenced CPT Codes** on page 585 of the 2010 AMA CPT Professional Edition. This appendix is a summary of CPT codes that **do not appear in numeric sequence** in the listing of CPT codes. Rather than deleting and renumbering, resequencing allows existing codes to be relocated to an appropriate location for the code concept, regardless of the numeric sequence.

The guiding principles for resequencing that were considered are:

- Resequence to allow placement of related codes to an appropriate location.
  - **New Codes:** assign the closest number available ad place concept in the desired location – does not need to be in numeric sequence. Attempts will be made to assign code numbers that fall within a family of anatomically
  - related procedures or a subsection, if no code number is available within a subsection or family, the closest code number will be assigned.
  - **Existing Codes:** relocate the existing code (without modifying the code number) to the desired location – does not need to be in numeric sequence
- Resequencing Symbol **“ # “**
  - The **“ # “** symbol (preceding any other symbols applied to the code) denotes a re-sequenced code
  - Example: **#** ▲ 46220 Excision of single external papilla or tag, anus

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2010 CPT UPDATES (CONTINUED)…

- References
  - References are inserted where the code would have been found numerically directing the user to the subsection where the resequenced code is located.
  - Example: 51797 ►Code is out of numerical sequence. See 51725-51798◄
  - Cross references, parenthetical notes, and introductory notes with code ranges affected by resequenced codes will be more explicit.

Resequencing will make it easy to mistake the meaning of a code if we assume its parent code is the code immediately before it. We can no longer make assumptions about the relationship of codes based on the numeric context. We recommend that full descriptions, not indented codes, be used. Resequencing may become problematic when ordering reports as the range of codes being requested will need to include the codes that are resequenced.

2010 Evaluation and Management (E/M)

(NOTE: The following pertains to AMA revisions. Centers for Medicare and Medicaid Services (CMS) have made extensive changes to consult coding. CMS Revisions to Consult Service Payment Policy MM6740 was released on December 14, 2009. Those instructions are included in a separate attachment. Updated information from CMS and National Government Services (NGS) is being received daily. This document is not intended to replace official CMS guidelines and only represents what was known at the time of publication on December 17, 2009.)

The Evaluation and Management (E/M) Services section of 2010 CPT did not receive any new codes; however, the 2010 E/M section does include extensive revisions to the guidelines for the Consults, Office and Other Outpatient Consults, and Inpatient Consults sections. Editorial revisions were made to the Nursing Facility Services codes and additional revisions were made to the guidelines of the Prolonged Services without Direct (Face-to-Face) Patient Contact subsection.

The consult definition included within the introductory notes under the E/M section subheading Consults has been revised to outline the two circumstances under which consults provided at the request of another physician or appropriate source may be rendered:

1. to provide opinion/services for a specific condition or problem, or
2. to allow a determination to be made on whether to accept the ongoing management of the patient's entire care or for the care of a specific condition or problem (ie, transfer of care).

Documentation of the written or oral request for a consult can be made by either the consultant or by the requesting physician or other appropriate source.

Another revision was made under subheading Consults to direct users to see the instructions in the Initial Hospital Inpatient Care and Initial Facility Care sections to determine how to code circumstances in which a patient is admitted to the hospital or nursing facility in the course of an office or other ambulatory facility visit.

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2010 CPT UPDATES (CONTINUED)…

Under the subsection Inpatient Consult an instructional note has been added referencing the Transfer of Care and Concurrent Care definitions found in the E/M Services Guidelines. This note also directs the use of subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310) for reporting any transfer of care services that occur in the hospital setting following the initial hospital or nursing facility care services. Further clarification includes:

1. reporting both an outpatient and inpatient consult related to the same inpatient stay is not appropriate; and
2. when transfer of care services are provided in the inpatient setting, whether hospital or nursing home, and a consult service by the same provider was already performed in the outpatient setting, use the subsequent hospital care codes (99231-99233) or subsequent nursing facility codes (99307-99310).

Other key points that the AMA made regarding consults/transfers are:

- Define "transfer" and attempt to distinguish from consults
  - advise and treat vs take over
  - documentation of request
  - transfer of care is the process whereby a physician who is providing management for some/all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility, and who from the initial encounter is not providing consultative services.
  - Services that constitute transfer of care (ie, are provided for the management of the patient's entire care or for the care of a specific condition or problem) are reported with the appropriate new or established patient codes for office or other outpatient visits, domiciliary, rest home services, or home services.
  - consult codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation, but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consult evaluation, regardless of the site of service.
- Define rules for admission services
  - one service per day
- Define rules for outpatient followed by inpatient services
  - one consult per stay
- Define concurrent care
  - concurrent care is the provision of similar services (eg, hospital visits) to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required.
- Define inpatient consults (including hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting)
  - only one consult should be reported by a consultant per admission
  - subsequent services during the same admission are reported using subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310), including services to complete the initial consult, monitor progress, revise recommendations, or address a new problem.

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2010 CPT UPDATES (CONTINUED)…

- transfer of care services should be reported using the subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310).
- do not report both an outpatient consult and inpatient consult for services related to the same inpatient stay.
  - All E/M services provided by the consultant related to the admission occurring on the same date of a patient's admission are reported with the inpatient consult service code (99251-99255).
  - If a patient is admitted after an outpatient consult (office, emergency department, etc) and the patient is not seen on the unit on the date of admission, only report the outpatient consult code (99241-99245).
  - If the patient is seen by the consultant on the unit on the same date of admission, report all E/M services provided by the consultant related to the admission with either the inpatient consult code (99251-99255) or with initial inpatient admission code (99221-99223, if the admitting physician.

- Initial nursing facility care (99304-99310, 99318) were revised to include terminology that is consistent with the description of unit/floor time that has been established to include the time spent at the patient's bedside and/or on the patient's facility floor or unit.
- Prolonged physician service without direct (face to face) patient contact includes revisions to the guidelines:
  - report for prolonged services that are beyond the usual non face to face component of physician service time.
  - removal of the add-on code status from 99358 and clarification that the prolonged services may now be reported on a different date than the primary service to which it is related.
  - 99358 and 99359 are no longer restricted to use on the same date as the related service; however must be related to ongoing patient management.
  - clarification not to report 99358 and 99359 for non face to face services that already have specific CPT codes such as medical tam conferences, on-line medical evaluations, care plan oversight services, anticoagulation Management or other non face to face services that have more specific codes and no upper time limit in the CPT code set.

2010 Anesthesia

CPT 01632 has been deleted for 2010 because of the low volume of shoulder procedures for which 01630 was reported.

- (01632 has been deleted. To report, see 01630, 01638)

2010 Integumentary

- General
  - Cross-reference has been added following CPT 10022 to direct the use of CPT 19295 for percutaneous of a localization clip during breast biopsies.

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2010 CPT UPDATES (CONTINUED)…

- Excision – Benign Lesions
  - In accordance with the establishment of new CPT 14301 and CPT 14302, these guidelines have been revised to expand the code range and support the establishment of these services.
- Excision – Malignant Lesions
  - Malignant lesion guidelines have been revised to expand the code range and support the establishment of CPT 14301 and CPT 14302.
- Adjacent Tissue Transfer or Rearrangement
  - New CPT codes
    - •14301 Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
    - +•14302 each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
    - CPT 14300 and CPT 14301 have been established to more accurately describe minimal and more extensive adjacent tissue transfer services.
  - Guidelines were revised to support the establishment of these services and to delineate that undermining alone of adjacent tissues to achieve closure, performed without additional incisions, does not constitute adjacent tissue transfer services. When performed the complex repair CPT 13100-13160 should be reported.
- Flaps (Skin and/or Deep Tissues)
  - Cross-references preceding CPT 15570 and following CPT 15650 have been revised to expand the code range and support the establishment of CPT 14301 and CPT 14302.
- Other Flaps and Grafts
  - New introductory guidelines for flap repairs and grafts have been added to provide clarification and appropriately define CPT 15740 and CPT 15750.
  - Cross-references following CPT 15750 have been added to instruct the appropriate reporting of CPT 14300 -14302 for random island flaps and other flaps from adjacent areas.
- Other Procedures
  - Cross reference following code 15830 has also been revised to support the establishment of codes 14301 and 14302.
- Destruction, Benign Or Premalignant Lesions

- Cross reference added to the Destruction Subsection to direct users to codes 96920-96922 for laser treatment for inflammatory skin disease.

- Breast
  - Code 19295 has been revised to include clip placement during fine needle aspiration, as described in code 10022. In accordance with the revision of code 19295, the instructional note following code 19295 has been revised to include code 10022, fine needle aspiration with imaging guidance.

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2010 CPT UPDATES (CONTINUED)…

2010 Musculoskeletal

New guidelines in the Musculoskeletal System subsection

1. define procedures related to excision of subcutaneous soft tissue tumors, excision of fascial or subfascial soft tissue tumors, excision of fascial or subfascial soft tissue tumors, radical resection of soft tissue tumors, and radical resection of bone tumor services,
2. explain the most appropriate method for code selection (eg, code selection is based on size and location of the tumor),
3. direct the user to report other services related to appreciable vessel exploration and/or neuroplasty and complex soft tissue repair or reconstructive (eg, adjacent tissue transfer(s), flap(s),
4. clarify that the work of simple or intermediate repair is inherent in these services,
5. instruct the user to report extensive undermining or other techniques used to close a defect created by skin excision when it requires a complex repair, and
6. instruct that dissection or elevation of tissue planes to permit resection of the tumor is included in the excision.

The guidelines further clarify that code selection is based solely on the location of the tumor, not on the size of the tumor or whether the tumor is benign or malignant, primary or metastatic. The guidelines also direct the user to report the excision of malignant lesion codes 11600-11646 for radical resection of tumors of cutaneous origin.

- General - Introduction or Removal
  - To support the deletion of code 77784, the cross reference note following code 20555 has been revised to reflect the appropriate codes for reporting interstitial radioelement application.
- Head – Excision
  - Five codes have been established in the Head section:
    - •21011 and •21012 describe excision of a subcutaneous soft tissue tumor of the face or scalp, less than or greater than 2 cm
    - •21013 and •21014 describe excision of a subfascial soft tissue tumor of the face or scalp, less than 2 cm
    - •21016 describe radical resection of a soft tissue tumor of the face or scalp, greater than 2 cm.
    - In support of these new codes look for ▲revisions to codes in this section.
- Neck (Soft Tissue) and Thorax
  - Excision
    - New •21552 established to report excision of a subcutaneous soft tissue tumor of the neck or anterior thorax, 3 cm or greater.
    - Code 21555 revised for standardization of the nomenclature
    - New •21554 established to describe excision of a subfascial soft tissue tumor of the neck or anterior thorax, 5 cm or greater
    - Code 21556 revised for standardization of the nomenclature
    - New •21558 established to describe radical resection of a soft tissue tumor of the neck or anterior thorax, 5 cm or greater
    - In support of these new codes look for ▲revisions to codes in this section.

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2010 CPT Updates (continued)…

- Back and Flank
  - Excision
    - New •21931 established to report excision of a subcutaneous soft tissue tumor of the back or flank, greater than 3 cm.
    - Code 21930 revised for standardization of the nomenclature
    - New •21932 and New •21933 established to report excision of a subfascial soft tissue tumor of the back or flank, less than or greater than 5 cm.
    - Code 21935 revised for standardization of the nomenclature
    - New •21936 established to report radical resection of a soft tissue tumor of the back and flank, greater than 5 cm.
- Spine (Vertebral Column)
  - Incision
    - Cross reference following the heading has been revised to include the appropriate codes to report injection procedures for facet joints.
  - Vertebral Body, Embolization or Injection
    - Codes 22520 and 22521 are revised to include the conscious sedation symbol, as this is an inherent part of these procedures.
    - Cross reference note that follows Code 22526 is revised to direct the user to report code 28999 for percutaneous intradiscal annuloplasty using a method other than electrotherm.
- Abdomen
  - Excision
    - Code 22900 revised for standardization of the nomenclature
    - New Codes •22901 established to report excision of a subfascial soft tissue tumor of the abdominal wall, greater than 5cm
    - New •22902 and •22902 established to report excision of a subcutaneous soft tissue of the abdominal wall, less than and greater than 3 cm
    - New •22904 and •22905 established to report radical resection
- Shoulder
  - Excision
    - New #•23071 and #•23073 established to report excision of a subcutaneous soft tissue tumor of the shoulder area 3 cm or greater and greater than 5 cm
    - New •23078 established to report radical resection of a soft tissue tumor of the shoulder area greater than 5cm.
    - In support of these new codes look for ▲revisions to codes in this section.
- Humerus (Upper Arm) and Elbow
  - Excision
    - New #•24071 established to report excision of a subcutaneous soft tissue of the upper arm or elbow area 3 cm or greater
    - New #•24073 established to report excision of a subfascial soft tissue of the upper arm or elbow area 5 cm or greater
    - New #•24079 established to report excision of a radical resection of a soft tissue of the upper arm or elbow area 5 cm or greater.

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2010 CPT UPDATES (CONTINUED)…

In support of these new codes look for ▲revisions to codes in this section.

- Forearm and Wrist
    - Excision
        - New #•25071 established to report excision of a subcutaneous soft tissue of the forearm and/or wrist area 3 cm or greater
        - New #•25073 established to report excision of a subfascial soft tissue of the forearm and/or wrist area 3 cm or greater
        - New •25078 established to report radical resection of a soft tissue tumor of the forearm and/or wrist area 3 cm or greater
        - In support of these new codes look for ▲revisions to codes in this section.
- Hand and Fingers
    - Excision
        - New #•26111 established to report excision of a subcutaneous soft tissue tumor or vascular malformation of the hand or finger 1.5 cm or greater
        - New #•26113 established to report excision of a subfascial soft tissue tumor or vascular malformation of the hand or finger 1.5 cm or greater
        - New •26118 established to report radical resection soft tissue tumor of the hand or finger 3 cm or greater
        - In support of these new codes look for ▲revisions to codes in this section.
- Pelvis and Hip Joint
    - Excision
        - New #•27043 established to report excision of a subcutaneous soft tissue tumor of the pelvis and hip area 3 cm or greater
        - New #•27045 established to report excision of a subfascial soft tissue tumor of the pelvis and hip area 5 cm or greater
        - New #•27059 established to report radical resection of a soft tissue tumor of the pelvis and hip area 5 cm or greater
        - In support of these new codes look for ▲revisions to codes in this section.
- Femur (Thigh Region) and Knee Joint
    - Excision
        - New #•27337 established to report excision of a subcutaneous soft tissue of the thigh or knee area 3 cm or greater
        - New #•27339 established to report excision of a subfascial soft tissue of the thigh or knee area 5 cm or greater
        - New #•27364 established to report excision radical resection of a soft tissue of the thigh or knee area 5 cm or greater
        - In support of these new codes look for ▲revisions to codes in this section.
- Leg (Tibia and Fibula) and Ankle Joint
    - Excision

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2010 CPT UPDATES (CONTINUED)…

- New •27616 established to report radical resection of a soft tissue tumor of the leg or ankle area 5 cm or greater
- New #•27632 established to report excision of a subcutaneous soft tissue tumor of the leg or ankle area 3 cm or greater
- New #•27634 established to report excision of a subfascial soft tissue tumor of the leg or ankle area 5 cm or greater
- In support of these new codes look for ▲revisions to codes in this section.

- Foot and Toes
  - Excision
    - New #•28039 established to report excision of a subcutaneous soft tissue tumor of the foot or toe area 1.5 cm or greater
    - New #•28041 established to report excision of a subfascial soft tissue tumor of the foot or toes 1.5 cm or greater
    - New •28047 established to report radical resection of a soft tissue tumor of the foot or toes 3 cm or greater
    - In support of these new codes look for ▲revisions to codes in this section..
- Application of Casts and Strapping
  - Body and Upper Extremity
    - Deleted 29220 for low back strapping as it is considered an obsolete procedure. Instruction to use an unlisted code 29799.
  - Lower Extremity
    - New •29581 established to report treatment f chronic venous insufficiency with multi-layer compression. Additional instructions also added.

2010 Respiratory System

- Nose
  - Excision
    - Deleted misleading parenthetical note that instructs the use of modifier 52 Reduced Services for reduction of turbinates.
  - Destruction
    - Revised ▲ 30801 and ▲30802 to clarify that radiofrequency ablation of the mucosa of the inferior turbinates are inherently included as part of the ablation service.
- Trachea and Bronchi
  - Endoscopy
    - Numerous revisions made to this section to clarify the descriptor by revising "with or without" language to "when performed" in regards to fluoroscopic guidance and cell washing.
    - New •31626 established to describe bronchoscopy with placement of fiducial markers.
    - New +•31627 established to describe bronchoscopy with computer assisted, image guided navigation, also referred to as navigational bronchoscopy.

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2010 CPT UPDATES (CONTINUED)…

- Watch for revisions to parent codes and family codes in this section.
- Lungs and Pleura
  - Introduction and Removal
    - New •32552 established to describe removal of an indwelling tunneled pleural catheter with a cuff.
    - New •32553 established to describe placement of percutaneous, intrathoracic placement of interstitial devices, such as fiducial markers or dosimeters.
  - Destruction
    - This section has been updated to reflect current practice in the performance of pleurodesis and fibrinolysis procedures.
    - New •32561 and New •32562 established to describe the instillation of an agent for fibrinolysis.

2010 Cardiovascular System

- Heart and Pericardium
  - Pacemaker or Pacing Cardioverter-Defibrillator
    - Editorial revisions that clarify the number of electrodes inserted, rather than the type of device (eg, single, dual, or multiple Cardioverter-defibrillator).
  - Transposition of the Great Vessels
    - New •33782 and New •33783 established to report aortic root translocation with ventricular septal defect and pulmonary stenosis repair for children requiring repair of transposition of the great arteries with ventricular septal defect and pulmonary stenosis.
  - Cardiac Assist
    - New •33981, New •33982 and New •33983 established to report placement of ventricular assist devices, as well as new guidelines to instruct the user how to report the new codes. These codes include the removal of the existing pump as well as the replacement.
  - Vascular Injection Procedures
    - New •36147 and New +•36148 established to report arteriovenous shunt imaging.
    - In support of these new codes look for ▲revisions and instructional notes in this section.
  - Hemodialysis Access, Intervascular Cannulation for Extracorporeal Circulation or "Shunt Insertion
    - Deleted 36834 as this service is already described under 36832.
    - Instructional notes also added
  - Portal Decompression Procedures
    - Revisions to this section to support the addition of moderate sedation symbols.
  - Ligation
    - New •37761 established to report ligation of subfascial perforator veins

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IMM INSIGHT

2010 CPT UPDATES (CONTINUED)…

- In support of these new codes look for ▲revisions and instructional notes in this section.

2010 Hemic and Lymphatic Systems

- General
  - Bone Marrow or Stem Cell Services/Procedures
    - Cross references revised to clarify that codes 38207 – 38209 should be used for freezing and thawing of bone marrow/stem cells harvest and preservation prior to therapeutic transplant or re-infusion, and not codes 88240 and 88241, which are intended to be used for freezing or thawing small amounts of tissue to be sent to another facility for diagnostic testing.

2010 Mediastinum and Diaphragm

- Diaphragm
  - Repair
    - Cross references added following 39502 and 39520 directing users to 43281 and 43282 for reporting laparoscopic paraesophagael hernia repair.

2010 Digestive System

- Pharynx, Adenoids, and Tonsils
    - Revision to 42894 to reflect use of this code for fasciocutaneous (fascia and skin) flaps, free muscle, skin, or fascial flaps as well as myocutaneous flaps (muscle and skin). Many of these defects that are currently being repaired using this procedure are currently being reconstructed using fasciocutaneous flaps.
- Esophagus
  - Laparoscopy
    - New •43281 and New •43282 established to report repair of paraesophagael via the laparoscopic approach, without implantation of mesh and with implantation of mesh.
- Stomach
  - Bariatric Surgery
  - New •43775 established to report a longitudinal gastrectomy (ie, sleeve gastrectomy) performed via a laparoscopy. Laparoscopic Sleeve Gastrectomy (LSG) is reported with New •43775.

- Rectum
  - Excision
    - New •45171 and New •45172 established to report excision of rectal tumor using a transanal approach.

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2010 CPT UPDATES (CONTINUED)…

- Instructional notes added that delete code 45170 and direct user to 45190 for destruction of rectal tumor using transanal approach.
- Anus
    - Large number of editorial changes. Watch for resequenced revised codes.
  - Repair
    - New •46707 established with the conversion of Category III 0170T to Category I status to report the repair of an anorectal fistula with a plug.
- Abdomen, Peritoneum, and Omentum
    - New •49411 established to describe interstitial device (eg, fiducial marker, dosimeter) placement using a percutaneous, intra-abdominal, intrapelvic, and/or retroperitoneal approach.

2010 Urinary System

- Bladder
  - Urodynamics
    - New •51727, New •51728, and New •51729 established to allow reporting of combination of services that are usually provided together for urodynamic studies.
    - To accommodate these new codes watch for deleted codes and revisions.
- Urethra
  - Other Procedures
    - New •53855 established to describe insertion of a temporary prostatic urethral stent. This new code replaces Category III code 0084T.

2010 Female Genital System

- Vagina
  - Endoscopy/Laparoscopy
    - New •57426 established to describe revision of a prosthetic vaginal graft using a laparoscopic approach, necessary due to infection.

2010 Maternity Care and Delivery

- Antepartum and Fetal Invasive Services
  - This subheading has been revised to include fetal invasive services to more accurately describe the procedures listed in this section.
  - Instructional notes and revisions are also included in this section.

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2010 CPT UPDATES (CONTINUED)…

2010 Nervous System

- Spine and Spinal Cord
  - Stereotactic Radiosurgery (Spinal)
    - Watch for instructional notes and revisions following the introductory guidelines.
  - Neurostimulators (Spinal)
    - New •63661, New •63662, New •63663, and New •63664 established to report the removal and the revision of a spinal neurostimulator electrode percutaneous array(s) and plate/paddle(s) procedures.
    - Deleted code 63660 previously used to report the above was too broad.
- Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System
  - Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic
    - New •64490 established to report injections into the paravertebral facet joints or nerves innervating the joint at the cervical or thoracic level. This code is reported for a single or the initial level treated.
    - New +•64491 established to report injections at the second cervical or thoracic level treated.
    - New +•64492 established to report injections at the third and any additional cervical or thoracic level treated.

2010 Eye and Ocular Adnexa

- While this section did not contain new codes for 2010 there are revisions to instructional notes.

2010 Auditory System

- While this section did not contain new codes for 2010 there are revisions to instructional notes.

2010 Radiology

- The most significant revisions to the Radiology section are the addition of a series of codes for CT colonography diagnostic and screening procedures, cardiac magnetic imaging codes and guidelines. In addition a new series of codes for CT and CTA of the heart, and myocardial perfusion and cardiac blood pool imaging studies have been added.
  - Gastrointestinal Tract
    - New •74261, New •74262, and New •74263 established to describe CT colonography. These codes support the deletion of codes 0066T and 0067T.

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2010 CPT Updates (continued)…

- Heart
  - New +•75565 established to report cardiac magnetic resonance imaging for velocity flow mapping.
  - Codes 75558, 75560, 75562, and 75564 have been deleted
  - New •75571, New •75572, New •75573, and New •75574 established to describe cardiac computed tomography (CT) and coronary computed tomographic angiography (CTA). The category III codes previously used have been deleted.
- Vascular Procedures Aorta and Arteries
  - New •75791 established to describe the performance of a radiological evaluation through an already existing access site into the shunt or from an access site that is not a direct puncture of the shunt.
- Radiation Oncology
  - New •77338 established to report multi-leaf collimator (MLC) design and construction for intensity modulated radiation therapy (IMRT).
- Nuclear Medicine Cardiovascular System
  - Deleted codes 78460, 78461, 78464, 78465, 78478, and 78480.
  - New •78451, New •78452, New •78453, and New •78454 established to replace codes 78460, 78461, 78464, and 78465 to clarify that when wall motion and ejection fraction are determined, they should be considered as part of the myocardial perfusion study and should not be separately reported.

2010 Pathology and Laboratory

The most changes are found in the Chemistry subsection of the Pathology and Laboratory section. There are several new codes, numerous editorial revisions, and a resequenced code.

- Chemistry
  - New •83987 established in support of archived CPT III 0140T for laboratory analysis of the pH of exhaled breath condensate, a test used to differentiate gastroesophageal reflux (GER) in asthmatic symptoms.
  - New •84145 established for reporting procalcitonin. This code replaces Category III code 0194T.
  - New •84431 established to report the total level of thromboxana production using urine as specimen to identify the individual who is taking aspirin but remains at risk of a cardiovascular event.
- Immunology
  - New •86305 established to report testing used for assessment of ovarian masses of uncertain origin that utilizes human epididymis protein 4 (HE4) bio-marker for monitoring cancer.

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2010 CPT UPDATES (CONTINUED)…

- New •86352 established to report the measurement of early response to immune system stimulation by determining the concentration of adenosine
- triphosphate (ATP) produced in CD4 positive cells selected from phytohemaglutinin-stimulated whole blood.
- New •86780 established to report Treponema pallidum.
- This section includes multiple ▲revisions.
- New •86825 established to report new methodology used for cross matching donor tissue with a patient serum sample.
- New +•86826 established as an add-on code to report each additional sample or sample dilution.

- Microbiology
  - Guidelines at the beginning of this subsection to provide clarification.
    - New •87150 established to report the amplified probe technique testing performed on secondary source specimens.
    - New •87153 established to report culture typing identification by nucleic acid sequencing method, each isolate.
- Surgical Pathology
  - New •88387 and New +•88388 established to report services performed prior to ancillary diagnostic testing currently applicable to molecular studies.
- In Vivo (eg, Transcutaneous) Laboratory Procedures
  - New •88738 established to report transcutaneous detection of hemoglobin (Hgb) and allow differentiation between transcutaneous Hgb measurement and invasive Hgb measurement performed on whole blood, in vitro.
- Reproductive Medicine Procedures
  - New •89398 established to report an unlisted testing procedure for reproductive medicine testing.

<u>2010 Medicine</u>

This section includes a significant amount of revisions.

- Immunization Administration for Vaccines/Toxoids
  - **Important Note: New Code 90470 and the revision of 90663 will not be published in the CPT 2010 codebook. These changes were made after the publication of the codebook.**
    - New •90470 established specific to the administration of H1N1 including counseling when performed and ▲revised code 90663 to report the influenza virus vaccine, pandemic formulation, H1N1.
- Special Otorhinolaryngologic Services
    - New •92540 established to report a number of services that have been combined from the Special Otorhinolaryngologic Services under the heading “Vestibular Function Tests, With Recording (eg, ENG)”.
- Audiologic Function Tests
    - New •92550 established to combine tympanometry impedance testing (92567) with acoustic reflex testing for threshold (92568)
    - New •92570 established to identify acoustic immittance testing.
    - This code combines a number of tests.

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2010 CPT Updates (continued)…

Cardiovascular

- Therapeutic Services and Procedures
  - Watch for editorial revisions in all sections.
  - Programming device evaluation codes and associated guidelines have been editorially revised to include the descriptor "in person" to clarify that these services are not performed remotely.
- Echocardiography
  - Editorially revised to indicate that certain codes include selected M-mode examination when they are performed. Also clarification on capturing the exercise portion of the study.
- Noninvasive Physiologic Studies and Procedures
  - New •93750 established to describe the in-person interrogation of a ventricular assist device (VAD).

- Pulmonary
  - Other Procedures
    - New •94011, New •94012, and New •94013 established due to the increased work and time involved in the performance of these procedures on uncooperative infants.
- Neurology and Neuromuscular Procedures
  - Nerve Conduction Tests
    - New •95905 established to report the performance of motor and sensory nerve conduction using pre-configured arrays.

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