

# CPT changes in 2000

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**T**his article provides an overview of the changes for general surgeons appearing in *Current Procedural Terminology 2000* (CPT 2000) and gives a brief status report on Medicare's carrier audits of the evaluation and management (E/M) codes. The portion of the article on new procedure codes is in code sequence, with a heading for each code or group of codes, permitting the reader to focus on codes he or she uses.

## **Wound repair**

For complex repair of wounds, new codes have been added for repairs longer than 7.5 cm. There are four new codes—one for each series of wound codes (trunk; scalp, arm, and/or legs; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; and eyelids, nose, ears and/or lips). The new codes are for the repair of each additional 5 cm or less of length and are to be reported in addition to the code for the repair of 2.6 cm to 7.5 cm. For instance, to report the complex repair of a 10 cm wound of the leg, report code 13121, *Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm,\** for the first 7.5 cm and code 13122, *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less*, for the remainder. If necessary, the code may be used more than once. A 14 cm complex repair of the leg, for example, would be coded using 13121 once and 13122 twice.

These new codes are “add-on” codes, which

means they must be reported with a specific base code; in this case the base code is the one for repair of a 2.6 cm to 7.5 cm wound in the same series of codes. The value for the add-on code only includes the repair of the wound; the pre- and postoperative work is included in the base code. Therefore, these new codes are exempt from the multiple surgery (-51) modifier and their value should not be discounted.

Two important clarifications are made in the introductory notes regarding the addition of the lengths when multiple wounds are repaired: do not add lengths from different groupings of anatomic sites and do not add different types of repairs. For example, reporting a single code containing a mixture of intermediate repairs from the scalp and neck would be incorrect. A single code reporting a mixture of intermediate and complex repairs would also be incorrect.

Both CPT and the Medicare program accommodate the reporting of wound closure using tissue adhesives, but in different ways. In CPT, there is a note of explanation that the codes in the wound repair section should be used to report closure using sutures, staples, or tissue adhesives, either singly or in combination with each other or in combination with adhesive strips. Medicare, on the other hand, established a HCFA Common Procedure Coding System (HCPCS) code, G0168, *Wound closure utilizing adhesives only*. When a skin adhesive is used along with sutures or staples, the service should be reported with a CPT code. Under either coding convention, wound closure using adhesive strips alone should be reported using an E/M code.

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### **Skin grafts**

For 1999, CPT added notes directing the use of CPT codes 15100-15121, split-thickness skin grafts, to report the use of tissue cultured skin grafts, including bilaminar skin substitutes or neodermis. Effective January 1, 2000, the application of tissue cultured skin grafts should be reported to Medicare using HCPCS codes G0170, *Application of tissue cultured skin grafts, including bilaminar skin substitutes or neodermis, including site preparation, initial 25 sq cm*, and G0171 for each additional 25 sq cm. Code G0171 is an add-on code for the intraoperative work of the additional area, so the multiple procedure modifier (-51) should not be used and the value of the procedure should not be discounted.

Two codes have been deleted to simplify the reporting of flaps. The first one is code 15580, *Cross finger flap, including free graft to donor site*. It should be reported using 15574, *Formulation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet*. The second deleted code is 15625, *Delay of flap or section of flap (division and inset); section pedicle of cross finger flap*. It should be reported using code 15620, *Delay of flap or section of flap (division and inset); at forehead, cheeks, chin, neck, axillae, genitalia, hands or feet*. Note that a conforming amendment, the deletion of the phrase "(except 15625)," has been made in code 15620.

### **Pacing cardioverter-defibrillator**

The introductory notes and several descriptors in codes 33200-33249 were revised to reflect the technology of the pacing cardioverter-defibrillator. Also, notes were added after several individual codes, primarily to assist with reporting various removals and reinsertions.

Two codes were deleted. Code 33242, *Repair of implantable cardioverter-defibrillator pulse generator and/or leads*, has been replaced by either code 33218, *Repair of a single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator*, or code 33220, *Repair of two transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator*. Code 33247, *Insertion or replacement of implantable cardioverter-*

*defibrillator lead(s), by other than thoracotomy*, has been replaced by 33216, *Insertion or repositioning of a transvenous electrode (15 days or more after initial insertion); single chamber (one electrode) permanent pacemaker or single chamber pacing cardioverter-defibrillator*.

### **Revision of lower extremity arterial bypass**

There are two new codes for an open revision of lower extremity arterial bypass graft. Code 35879 is for *Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty*. Code 35881 is for *Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition*.

### **Intervascular cannulization or shunt**

A new code has been established for creation of an anastomosis between the basilic vein and brachial artery in the upper arm, which is allowed to mature into a functioning arteriovenous fistula. It is 36819, *Arteriovenous anastomosis, open, by basilic vein transposition*. This procedure is used, for example, after either an autogenous or a non-autogenous graft in the upper or lower arm has thrombosed and failed.

### **Laparoscopy**

The entire section headed Laparoscopy/Hysteroscopy (codes 56300-56399) has been eliminated, with the codes moved to the appropriate anatomic positions and renumbered. For instance, the two codes for laparoscopic-guided transhepatic cholangiography, the three codes for laparoscopic cholecystectomy, and the code for laparoscopic cholecystoenterostomy have been moved to a heading of laparoscopy under the biliary tract and renumbered from 47560 to 47570. The laparoscopic codes are immediately ahead of the excision codes, which include the open cholecystectomy codes, and the repair codes, which include the open cholecystoenterostomy. There is a note at the beginning of the section directing the user to 49320 for a diagnostic laparoscopy of the abdomen, peritoneum, and omentum, and a new unlisted code at the end of the section, 47579 *Unlisted laparoscopy procedure, biliary tract*. Other laparoscopic codes follow a similar structure, including the reference to a diagnostic laparoscopy and an unlisted procedure specific to that anatomic site. The table on

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page 34 shows the old and new code numbers for procedures of interest to general surgeons.

There are also new codes for laparoscopic nephrectomy. Code 50546 is for *Laparoscopy, surgical; nephrectomy*, and code 50547 is for *Laparoscopy, surgical; donor nephrectomy from a living donor (excluding preparation and maintenance of allograft)*.

### **Diaphragm repair (resection)**

Two new codes were added for resection of the diaphragm. Code 39560 is for *Resection, diaphragm; with simple repair (e.g., primary suture)*, and code 39561 is for *Resection, diaphragm; with complex repair (e.g., prosthetic material, local muscle flap)*.

### **Gastric procedures**

The phrase "any method" was added to code 43761 so it becomes *Repositioning of the gastric feeding tube, any method, through the duodenum for enteric nutrition*. This allows, for example, for repositioning the gastric feeding tube through the duodenum by blindly advancing it and confirming the position by X ray or by positioning it under fluoroscopy (and coding for radiological supervision and interpretation using 74350).

Editorial changes were also made to the gastrostomy codes with the deletion of the designation of temporary and permanent from codes 43830 and 43832, respectively. Code 43830 becomes *Gastrostomy, open; without construction of gastric tube (e.g., Stamm procedure) (separate procedure)* and code 43832 becomes *Gastrostomy, open; with construction of gastric tube (e.g., Janeway procedure)*. The changes allow the description of the procedure itself, regardless of how long the tube will be in place. The term "separate procedure" in code 43830 means that the placement of the gastrostomy tube can only be reported when it is done alone (or with an unrelated procedure); it cannot be reported in addition to a procedure of which it is considered an integral part.

### **Starred ( \* ) procedures or items**

Throughout the surgical section of CPT, a star ( \* ) following the procedure number has indicated a relatively minor service with variable pre- and postoperative periods. Therefore, the

service has included only the listed surgical procedure, with postoperative care and complications added on a service-by-service basis.

A change is being made in the way CPT directs physicians to report an office or other outpatient visit or consultation on the same date as the starred surgical procedure when the visit (E/M code) is for a separately identifiable service. In that case, CPT now says that the visit is reported with a modifier -25 attached to the visit, indicating that the visit was for a separately identifiable E/M service. The E/M service and the starred procedure may be for the same or a different diagnosis.

For example, a general surgeon is asked to evaluate a 48-year-old woman with a new breast mass. He performs the appropriate level of office or other outpatient consultation; he documents the visit by recording the request by the referring physician for the consultation, the history obtained, the physical examination performed, and any indication of the complexity of medical decision making. The surgeon also determines that a core biopsy of the mass is indicated and he performs that on the same date as the consultation. He documents the procedure in a separate note from the consultation service. The procedure note should include the anesthesia used (if any), the procedure in detail and, if necessary, the indications for the procedure. The consultation is reported with the -25 modifier indicating that the consultation was a separately identifiable service. The core biopsy is reported as code 19100. The ICD-9-CM code for both services is 611.72, *Lump or mass in breast*.

The CPT rules are unchanged for handling a visit in the hospital, where the appropriate E/M code is added to the starred procedure. They also remain the same for handling an initial office visit when the starred procedure is the *major* service at the visit; procedure code 99025, *Initial (new patient) visit when starred ( \* ) surgical procedure constitutes major service at that visit* is added instead of a regular visit. No modifiers are used in either situation.

The CPT rules have changed, but there are many payors who do not follow the CPT rules regarding starred procedures. Because there is so much variation in reporting practices, be sure to look for any guidance from payors regarding

## Relocation of laparoscopic procedures

1999 code	2000 code	1999 CPT descriptor*
56300	49320	Laparoscopy (peritoneoscopy), diagnostic; (separate procedure) <sup>†</sup>
56305	49321	Laparoscopy, surgical; with biopsy (single or multiple)
56306	49322	with aspiration (single or multiple) <sup>†</sup>
56310	44200	enterolysis (freeing of intestinal adhesion) (separate procedure)
56311	38570	with retroperitoneal lymph node sampling (biopsy), single or multiple
56312	38571	with bilateral total pelvic lymphadenectomy
56313	38572	with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple
56314	49323	with drainage of lymphocele to peritoneal cavity
56315	44970	appendectomy
56316	49650	repair of initial inguinal hernia
56317	49651	repair of recurrent inguinal hernia
56321	60650	with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal
56322	43651	transection of vagus nerves, truncal
56323	43652	transection of vagus nerves, selective or highly selective
56324	47570	cholecystoentostomy
56340	47562	cholecystectomy, (any method) <sup>†</sup>
56341	47563	cholecystectomy with cholangiography
56342	47564	cholecystectomy with exploration of common duct
56345	38120	splenectomy
56346	43653	gastrostomy, temporary (tube or rubber or plastic) (separate procedure) <sup>†</sup>
56347	44201	jejunostomy (e.g., for decompression or feeding)
56348	44202	intestinal resection, with anastomosis (intra or extracorporeal)
56349	43280	esophagogastric fundoplasty (e.g., Missen, Belsey IV, Hill, Toupet procedures) <sup>†</sup>
56362	47560	Laparoscopy with guided transhepatic cholangiography; without biopsy
56363	47561	with biopsy

\*CPT codes and descriptors only are © American Medical Association, 1999.

<sup>†</sup>CPT descriptor was editorially revised for 2000.

possible changes in their policies. The Medicare policy, which has not followed the starred procedure rules, remains unchanged: a visit is reported with a -25 modifier whenever a separately identifiable visit is performed, regardless of whether the procedure had a star beside it.

### ***E/M codes***

We wanted to take advantage of this opportunity to provide a brief status report on what is happening in the Medicare program with the E/M codes, including the audits that are being done of E/M codes, which documentation guidelines (DGs)

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to use, and what is happening with the latest version of the DGs.

Medicare carriers are continuing to perform random pre-payment reviews of E/M codes. Carriers are also continuing to include E/M codes in their post-payment reviews if there is reason to suspect a problem with the physician. A full explanation of what happens during either type of review is well beyond the scope of this article. However, regardless of the type of audit being performed the approach is the same: the carrier will ask for the medical record involved and will examine that record using the DGs to determine whether it supports the claim.

In conducting their reviews, carriers have been instructed to apply the 1995 or 1997 edition of the DGs, whichever is more advantageous to the physician. Since some claims may come out better using the 1995 DGs and others, from the same physician, may do better using the 1997 DGs, this is to be done on a claim by claim basis.

The 1995 and 1997 DGs provide virtually identical guidance on selecting and documenting the levels of history and medical decision making. The major difference between the two versions is in the physical examination, with the 1995 edition containing only a multi-system examination and the 1997 edition containing 10 single organ system examinations and a different, probably more difficult, multisystem examination. The single system examinations are: cardiovascular; ear, nose and throat; eye; genitourinary; hematologic/lymphatic/immunologic; musculoskeletal; neurologic; psychiatric; respiratory; and skin.

The carriers will use the DGs to examine medical records and will make payment for a lower level of service if they cannot find support for the level of service reported. Regardless of which version of the DGs the surgeon is using, the documentation must show the history obtained, the physical examination performed, and the complexity of medical decision making. The latter includes the number of diagnoses and/or management options, the amount and complexity of data to be reviewed, and the risk of significant complications; documentation of the complexity of medical decision making may be either expressed or implied in the medical record.

The carriers will also be sure the special requirements for a consultation are met; if they are not

met, they will make payment for a “regular” hospital or office visit. Those special requirements are (1) the consultation was requested by another physician (or other qualified person), and (2) the consultant provided a written report of findings to the requesting physician (or other qualified person).

There is also a 1999 set of DGs that is not yet in use. These DGs were developed in response to criticism of the 1997 version of the DGs—criticism that can most succinctly be described as “too complicated.” The 1999 set of DGs is streamlined so that there is only a single set of requirements rather than the individual requirements for different organ systems in the 1997 set of DGs. HCFA is now pursuing a two-part approach to the 1999 version of the DGs. The first is to evaluate the new DGs, seeing what impact the changes are apt to have on the reporting of E/M services and whether they wish to make any changes in them. The second is to conduct a pilot test of the DGs in a few locations. As of this writing, however, the testing will not begin before the spring of 2000. □

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