



CPT changes in 2001

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This article covers changes in *Current Procedural Terminology 2001* (CPT) that are of special interest to general surgeons and their staffs. The changes are presented in code sequence to facilitate finding frequently performed procedures. This article provides CPT coding rules. Each insurance plan determines payment policies unique to that plan; therefore, the payment rules for a given plan may be different from those reported here.

If your practice reports home health care plan oversight codes or observation care codes to Medicare, you should read "What surgeons should know about... The 2001 Medicare fee schedule" on pages 8-13 in this issue of the *Bulletin*. The Health Care Financing Administration (HCFA) has established separate HCFA Common Procedure System (HCPCS) codes for care plan oversight and has announced policies for using the observation care codes (codes 99217-99220 and 99234-99236) that are not reflected in CPT.

Wound repair

Revisions have been made in the notes for both excision of malignant skin lesions (codes 11600-11646) and repair or closure of wounds (codes 12001-13160) to clarify two aspects of the closure of wounds. The first is that excision of a malignant skin lesion includes simple repair (one-layer closure), but repair by intermediate closure (layered closure) or complex closure (more than layered closure) is reported in addition to the excision of a malignant lesion. The second is to clarify the meaning of creation of a defect in the notes for repair of a wound. Excision of a scar requiring complex repair has now been added to the notes as an example of creation of a defect for repair.

Note also that two new codes for selective and non-selective debridement without anesthesia (codes 97601 and 97602) have been added to report services generally performed by physical therapists and other nonphysician practitioners. The debridement of wounds by surgeons continues to be properly reported with a code from the range 11040-11044.

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Skin grafts

Since 1999, CPT has directed physicians to use codes 15000-15121, split-thickness skin grafts, to report use of tissue cultured skin grafts, including a bilaminar skin substitute or neodermis. Now there are two new CPT codes for the application of a bilaminar skin substitute or neodermis. They are code 15342, *Application of bilaminar skin substitute/neodermis; 25 sq cm*, and code 15343, *Application of bilaminar skin substitute/neodermis; each additional 25 sq cm*. Code 15000, *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq cm or one percent of body area of infants and children*, should be used to report initial wound preparation. Code 15343 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.

Medicare established codes for 2000 in HCPCS for reporting the application of tissue cultured skin grafts including site preparation. Those codes (G0170 and G0171) are being deleted, and CPT codes are to be used instead, including the use of code 15000 for the initial wound preparation.

Local treatment of burns

Code 16035, *Escharotomy*, has been revised to read *Escharotomy; initial incision* and code 16036 has been added for each additional incision. Code 16036 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.

Breast biopsy

The existing code for a percutaneous needle core biopsy was split into two: a new code using imaging guidance (19102) and a revised code not using imaging guidance (19100). There also is a new code 19103, *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance*. The vacuum assisted device is called a Mammotome and the rotating biopsy device is called an ABBI. Code 19125, *Image guided placement, metallic localization clip, percutaneous,*

during breast biopsy, was added to recover the fairly substantial expense of the clip when it is supplied by the surgeon rather than because of the work involved in placing the clip. Finally, a number of editorial changes were made, primarily to designate certain procedures as open. For imaging guidance, code 76095 for stereotactic localization, code 76096 for mammographic guidance, or code 76942 for ultrasonic guidance should be used.

There are errors in the cross-reference notes in both the surgery section and the radiology section. We believe that the changes described below are correct, although they have not yet been approved for inclusion in CPT. In the surgery section, the entire third note under code 19100 should be deleted since the procedure does not use imaging guidance. In the existing cross-reference under code 19103, code 76096 should be added to the note. Under code 19291, the note on radiological supervision and interpretation should include codes 76095 and 76942. Under code 19295, the cross-reference should be to code 19103 in addition to code 19102. In the radiology section, the first cross-reference under code 76095 should not include code 19100. In the first cross-reference under code 76096, code 19000 should be deleted.

Anterior approach to the spine

For a long time, there has been confusion over how general and thoracic surgeons should report doing the anterior approach to the spine. Historically, three methods of reporting the services have been used. Both the surgeon doing the approach and the spine surgeon reported the definitive procedure with the co-surgeons modifier attached (modifier -62); the approach surgeon reported an exploratory thoracotomy (code 32100), exploratory laparotomy (code 49000), or exploration of the retroperitoneal area (code 49010) and the spine surgeon reported the definitive procedure; or the approach surgeon used an unlisted procedure (codes 22899, 22999, 32999, or 49999) and the spine surgeon reported the definitive procedure.

In the notes in the spine section (musculoskeletal system) for 2001, there is an explanation of the correct way to report an anterior approach. Under this description, both the approach and the spine surgeons should use the definitive procedure code with a co-surgeon modifier (modifier -62). This

applies to codes 22112-22114, 22222-22224, 22556-22558, 22808-22812, 63077, 63085, 63087 and 63090.

Each of the code families has an add-on code for each additional interspace or each additional segment. If performed, this is to be reported by the spine surgeon. For example, both the approach surgeon and the spine surgeon may report a minimal discectomy (code 22558-62) but only the spine surgeon may report the additional interspace code and a code for an allograft. Unfortunately, CPT used confusing language in explaining how the add-on codes are to be reported, but the example in CPT provides correct guidance. The modifier *cannot* be attached to the codes for the additional levels; those are codes 22116, 22226, 22585, 63079, 63086, 63088 and 63091.

Endovascular repair of AAA

A new section of CPT has been added to describe the endovascular repair of an infrarenal abdominal aortic aneurysm (AAA) or dissection. When used with pre-existing catheter codes and new fluoroscopic guidance codes, it is possible to completely describe the placement of various prosthetic devices. There are also codes for the open repair of an infrarenal abdominal aortic aneurysm or dissection following a failed endovascular repair. The 12 codes in the new section include all catheter manipulations necessary in placing the endoprosthesis and balloon angioplasty within the endovascular site to assure full expansion of the endoprosthesis.

There are three new codes for reporting the repair itself: code 34800 using an aorto-aortic tube prosthesis, code 34802 using a modular bifurcated aortic prosthesis (one docking limb), and code 34804 for use of a unibody bifurcated prosthesis. There are two codes for placement of an extension of a prosthesis. Code 34825 is for placement of a proximal or distal extension of the prosthesis in the initial vessel and code 34826 is an add-on code for placement of an extension in each additional vessel.

The aortic endograph procedure begins after placement of appropriate guidewire catheters and performance of the “roadmapping” aortogram prior to deployment of the endoprosthesis. Existing catheterization codes (code 36200, 36245, and so on) are used to report these maneuvers. There are two new codes for reporting the open exposure

of the iliac artery (code 34820) or femoral artery (code 34812) when needed to allow passage of the endovascular prosthesis. Both of these codes are unilateral. There are two new add-on codes to report the endovascular placement of an iliac artery occlusion device (code 34808) and the placement of a femoral-femoral prosthetic graft (code 34813).

The new section on endovascular repair of an AAA also contains three codes for the open repair following a failed endovascular repair, including the repair of arterial trauma from the failed procedure. They are code 34830 when a tube prosthesis is used for the repair, code 34831 for use of an aorto-bi-iliac prosthesis, and code 34832 for use of an aorto-bifemoral prosthesis.

For fluoroscopic guidance, two new codes have been added. Code 75952 is for angiography of the aorta during the basic repair (procedures 34800-34808) and code 75953 is for angiography during the placement of an extension prosthesis (procedures 34825 and 34826).

Percutaneous arteriovenous fistula

Code 36870 was added for percutaneous thrombectomy of an arteriovenous fistula with an autogenous or nonautogenous graft, including mechanical thrombus extraction and intra-graft thrombolysis. This caused an editorial revision to three similar existing codes to make it clear that they are open procedures. They are codes for thrombectomy of a dialysis graft without revision (code 36831), revision of a dialysis graft without thrombectomy (code 36832), and revision of a dialysis graft with thrombectomy (code 36833). Those three codes are designated “separate procedure,” which means they can only be used to report things that are not part of a bigger procedure.

Biopsy or excision of lymph nodes

The code for the biopsy or excision of superficial lymph nodes (code 38500) and the code for biopsy or excision of internal mammary node(s) (code 38530) have had the designation “separate procedure” removed to permit reporting a sentinel lymph node biopsy. The term “separate procedure” means that the code is an integral part of a total procedure and that both the component part of the procedure and the total procedure cannot be re-

ported together. Notes were added to continue the prohibition on reporting both the component part and the total procedure together. Code 38500 is not to be reported with radical lymphadenectomies (38700-38780) and code 38530 is not to be reported with a more limited range of lymphadenectomies (codes 38720-38746).

Intestinal transplantation

Four codes were added for intestinal transplantation. There are two codes for donor enterectomy with preparation and maintenance of the allograft—code 44132 is from a cadaver donor, and code 44133 is a partial allograft from a living donor. There are two parallel codes for intestinal transplantation from a cadaver donor (44135) and from a living donor (44136).

Endoscopies of the small bowel and rectum

A total of seven codes were added to various endoscopies of the small bowel and rectum for transendoscopic stent placement. The codes are 44370, 44379, 44383, 44397, 45327, 45345, and 45387. As with all endoscopies, a diagnostic endoscopy is always included, and the new codes include predilation of the stent placement site.

Two codes also were added to the flexible sigmoidoscopy family of codes. Code 45341 is for a sigmoidoscopy with endoscopic ultrasound examination. Code 45342 is for a transendoscopic ultrasound-guided fine-needle aspiration or biopsy. The fine-needle aspiration or biopsy may be performed within the rectum or through the rectum wall. Again, a diagnostic endoscopy always is included with both codes and code 45342 is only reported once, regardless of how many biopsies are taken.

Laparoscopic procedures

Code 47379, *Unlisted laparoscopic procedure, liver* was added. This procedure code should be used any time a procedure not listed in CPT is done. For example, performing laparoscopic radio-frequency ablation of hepatic tumors would be reported using this code. Always submit an operative note and any other documentation the insurance company wants with the claim.

The family of codes starting at 49320 is revised

to clarify that 49320 is a diagnostic procedure and the remaining codes in the family are surgical in nature. A new code, 50545, was added for a radical nephrectomy performed laparoscopically. It includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes and an adrenalectomy. The existing code for a nephrectomy (50546) was modified to include a partial ureterectomy.

Stress incontinence

A new code 57287, *Removal or revision of sling for stress incontinence (e.g., fascia or synthetic)*, was added.

Operating microscope

Code 69990, *Use of operating microscope*, is an add-on code for the use of the operating microscope. However, it is not to be used when the use of the operating microscope is included in the substantive procedure; the notes for code 69990 list the codes that include the use of the operating microscope. Code 15842, *Graft for facial nerve paralysis; free muscle graft by microsurgical technique*, has been in CPT for some time but has just now been added to the list of codes in the notes.

Altered surgical field modifier

A new modifier (modifier -60) has been established to report that a surgical procedure involved
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cant injuries. Patients with significant injuries had more operations, longer hospital stays, and higher hospitalization costs compared to patients without significant injuries.


Conclusions: Low-energy trauma may produce significant injuries, predominantly intracranial and skeletal. Trauma care providers should be cautious about

dismissing such patients based on the trivial mechanism of injury. Patients with low-level falls who are older than 55 years and not severely intoxicated have a high likelihood for significant injuries. Resources should be spent rationally for patients who do not have these characteristics because the probability of significant injuries among them is low, but not zero.

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increased operative complexity and/or time in a significantly altered surgical field. The modifier should be used when the surgical field has been altered by the effects of prior surgery (including marked scarring or adhesions), inflammation or infection, distorted anatomy, irradiation, very low weight (that is, neonates and infants less than 10 kg), and/or trauma. The language for modifier -22 (unusual procedural services) has been revised to indicate that services involving an altered surgical field should be reported using modifier -60 instead of modifier -22.

At press time, HCFA staff had said they were preparing instructions for Medicare carriers on the

altered surgical field modifier. They were planning to tell carriers not to recognize the new modifier. Instead they are to continue to recognize modifier -22 (unusual procedural services) as they had done in 2000. That means that surgeons should continue to report modifier -22 as they did in 2000 and Medicare will continue to review the cases and make additional payment when their criteria is met, as they did in 2000. We will report again in a "Socioeconomic tips of the month" article in the *Bulletin* on the Medicare instruction when it has been released. We have no information about how other third-party payors plan to react to modifier -60. 

Coding workshops

The College will be hosting 10 coding workshops for the first half of 2001. We have a new one-day format, for all surgeons, with a new consultant. The program, Coding and Documentation: The Keys to Reimbursement, will present both CPT and ICD-9-CM coding for surgeons and their office staff that is basic to intermediate. The program will include an interactive networking lunch to assist in meeting other colleagues with similar coding issues. Earn eight Category 1 CME credit hours.

Dates and locations:	February 22, 2001	Wyndham Anatole, Dallas, TX (program in conjunction with the February 23-24 North Dallas Chapter meeting)
	February 24, 2001	Hilton Ft. Lauderdale Airport, FL
	March 30, 2001	Doubletree Crystal City, Arlington, VA
	March 31, 2001	Crown Plaza, Secaucus, NJ
	April 28, 2001	Pointe Hilton at Squaw Peak, Phoenix, AZ
	May 10, 2001	Sinclair Community College, Dayton, OH (program in conjunction with the May 10-12 Ohio Chapter meeting)
	May 27, 2001	Hilton San Francisco, CA
	June 22, 2001	ACS Headquarters, Chicago, IL
	June 23, 2001	Lake Lawn Resort, Delavan, WI

For further registration information, contact Diane Mazmanian at 312/202-5406; fax: 312/202-5021; e-mail dmazmanian@facs.org.