CPT changes in 2003: An overview

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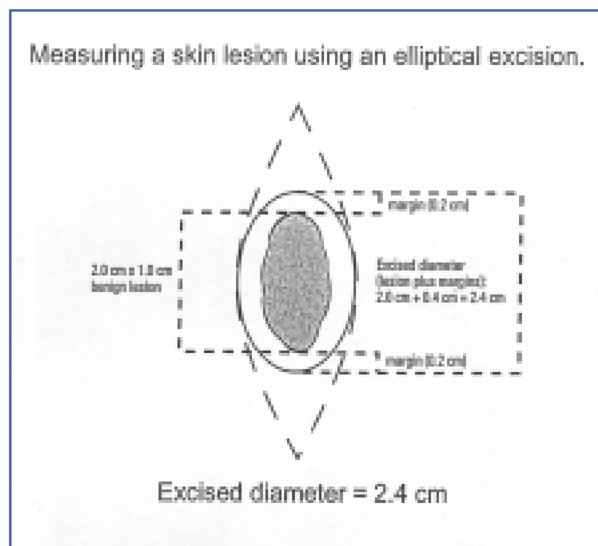
This article provides an overview of the new and revised *Current Procedural Terminology* (CPT) codes for 2003 that are of special interest to general surgeons and closely related subspecialties.*

Medicare traditionally has allowed physicians a three-month window, from January 1 to March 31, to switch to the new codes. However, the program will not implement the 2003 fee schedule and new codes until March 1. Most of the work to install new codes can be done before then, but the codes cannot be "turned on" until claims are being prepared for dates of service on or after March 1. Claims using new 2003 CPT codes submitted before March 1 will be held and processed after that date.



Skin procedures

The introductory notes and codes for the excision of benign and malignant skin lesions have been revised to clarify that the code should be selected and reported based on the size of the excision (lesion plus margins). Some organizations, including the College, taught physicians to report the size of the lesion, which is what was formerly stated in CPT. However, other organizations taught physicians to report the size of the defect created, and that language was adopted for CPT 2003. The language in the code descriptors has been changed from "lesion diameter" to "excised diameter," but codes and the sizes in the code descriptors have not changed. This means that physicians will report a higher level code in many instances. This upward shift will be especially pronounced in the series of codes for the excision of malignant lesions.

The introductory notes have been changed to make the following points:

- The measurement of the lesion plus excised margins should be made before the lesion is removed.
- For irregular lesions, the measurement should be made at the lesion's widest point and at the most narrow margin required to adequately excise the lesion (for example, when you use an elliptical excision to permit better closure). See the illustration on this page of measuring a lesion using an elliptical excision.
- In the event a frozen section pathology report shows the margins were inadequate and additional excision(s) is performed in the same setting, use only one code, selected based on the total diameter of the excised lesion plus all excised margins (that is, what the excised size would have been if it all been removed initially).
- If the re-excision is performed in a separate operative session but is within the global period of the first excision, report the second excision with a -58 modifier to indicate that more extensive surgery was done within the global period. (Use a -59 modifier to indicate that the surgery was done at a separate operative session if both procedures are done on the same day.)

The CPT manual contains three drawings explaining how to measure the defect. Unfortunately, the wrong text is attached to the drawings in some editions of the book, making it difficult to understand the illustrations. The correct text is shown in the box on the next page. Make pen and ink changes in all copies of CPT in the office.

Code 15756, *Free muscle or myocutaneous flap with microvascular anastomosis,* has been revised to clarify that the code should be used to report a skin flap procedure rather than a skin-graft procedure. The old descriptor contained the language "with or without skin" which was misinterpreted as describing skin grafts.

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Pediatric procedures

A new modifier -63 reflects the additional work of surgical procedures performed on infants weighing less than four kilograms. The modifier may be used on codes 20000-69999 in the surgery section of CPT except for those procedures that are done only on small infants. Reimbursement for procedures done only on small infants already reflects the increased work associated with the procedure.

Two codes have been added for minimally invasive repair of pectus excavatum (Nuss procedure). Code 21742 is for a procedure that does not include a thoracoscopy and 21743 is for a procedure that does include a thoracoscopy. Finally, an editorial change has been made to code 21740, to clarify that it is the open procedure to repair pectus excavatum or carinatum.

Pacemaker, related procedures

Coding for the insertion and revision of a pacemaker or pacing cardioverter-defibrillator has changed for 2003. Until this year, codes 33216 and 33217 were used to report both insertion and repositioning of pacing electrode(s) 15 days after the initial insertion. Codes 33216 and 33217 are now limited to describing insertion of the device(s). Two new codes were established to report electrode repositioning or replacement any time after the initial insertion. They are code 33215 for repositioning of transvenous electrode(s) implanted in the right atria or right ventricle, and code 33226 for repositioning of cardiac venous system electrode(s) implanted in the left ventricle. Code 33226 includes removal, insertion, and/or replacement of a generator.

Previous coding guidance was that procedures in this section included repositioning and replacement during the first 14 days after insertion or reinsertion of a device. That language has been deleted from the introductory notes. If a reinsertion or repositioning procedure does occur within the postoperative period of the initial insertion, then the appropriate CPT modifier (such as modifier -78) should be appended to the procedure code.

Two new codes and related introductory notes have been added to report insertion of pacing electrodes for left ventricle pacing. The first is standalone code 33224, *Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion and/or replacement of generator).* The second is add-on code 33225, *Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system).* Finally, code 33226, *Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of generator),* has been added.

Skin lesions

Check CPT and make the following corrections, if necessary, in the captions of the drawings that appear on the first page of the surgery section.

A. Example: excision, malignant lesion of the back, 1.0 centimeters [*sic*]. Code 11606.

B. Example: excision, of benign lesion of the neck, 1.0 centimeter by 2.9 centimeters. Code 11423.

C. Example: excision, malignant lesion of the nose, 0.9 centimeters with skin margins of 0.6 centimeters. Code 11642.

Vascular surgery

A new code, 34900, *Endovascular graft replacement for repair of iliac artery (e.g., aneurysm, pseudoaneurysm, arteriovenous malformation, trauma),* makes coding repair of iliac artery aneurysms analogous to aortic aneurysms. Balloon angioplasty within the target treatment zone is included in the code and is not separately reportable. Open femoral or iliac artery exposure, introduction of guidewires and catheters, and extensive repair of an artery is not included in code 34900 and may be separately reported. Procedure 34900 is a unilateral code, so for a bilateral procedure the -50 modifier must be attached. Code

Laparoscopic colectomy procedures

44206	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)
44207	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)
44208	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy
44210	Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy
44211	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, with or without rectal mucosectomy
44212	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy
44238	Unlisted laparoscopy procedure, intestine (except rectum)
44239	Unlisted laparoscopy procedure, rectum

75954 was added for the radiological supervision and interpretation of an endovascular iliac artery aneurysm repair. In addition, some conforming changes were made in existing codes. Code 34812 was revised by deleting the word "aortic" to allow use of this code for open exposure of the femoral artery during endovascular iliac aneurysm. Code 34825 was revised to include the placement of an extension prosthesis during iliac aneurysm repair as well as the infrarenal abdominal aortic aneurysm repair.

One new code was added to describe the creation of a conduit to allow the introduction of large carriers and endoprostheses used in repairing infrarenal and iliac artery aneurysms. Code 34833 contains the descriptor *Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral.* Note that code 34820, *Open iliac artery exposure for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral* is the same as code 34833, except it does not include "with creation of conduit." Be sure you select the correct code. Code 34820 should be used if the iliac artery is exposed but a conduit is not sutured in place, while code 34833 should be reported if a conduit is added. Remember that all of the work of code 34820 is included in code 34833, and the two codes should never be reported simultaneously for work on one iliac artery.

Code 34834 is new and should be used to report open brachial artery exposure when required for deployment of infrarenal aortic or iliac endovascular prosthesis. This code is analogous to the existing and much more commonly reported open femoral artery exposure, code 34812.

There is a new add-on code, 35572, *Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure (including the aortic, vena caval, coronary, peripheral artery).* This code may be used with coronary artery bypass graft (CABG) procedures using venous grafting (codes 33510-33523), venous reconstruction (codes 34502 and 34520), certain open aneurysm repairs (codes 35001-35002, 35011-35022, 35102-35103, and 35121-35152), vessel repairs using a vein graft (codes 35231-35256), bypass graft with vein (codes 35501-35587), open revision of a lower extremity bypass graft (codes 35879-35881), and excision of an infected graft (codes 35901-35907).

Code 37500, *Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS),* was added and the descriptor for code 37760 was revised to indicate that it is for the open procedure. Code 37501, *Unlisted vascular endoscopy procedure,* was added as well. The introductory notes indicate that a vascular endoscopy always includes a diagnostic endoscopy.

Category III codes have been established for new technology or for services that are not widely accepted. Eight codes were added to the Category III section of CPT for endovascular thoracic aor-

tic aneurysm (TAA) repair. Five surgical codes were added for TAA repairs (codes 0033T-0037T) and three codes were added for the radiological supervision and interpretation of the procedure (codes 0038T-0040T). To facilitate proper reporting, if a Category III code is available for a procedure, it must be used instead of an unlisted Category I code.

Colon-rectal procedures

A new series of codes was established to describe partial and total laparoscopic colectomy procedures. See the box on page 19 for a complete listing of the new codes. Note that the code to report unlisted intestinal laparoscopic procedures, code 44209, has been deleted and replaced by a new code, 44238. Finally, code 44239, *Unlisted laparoscopy procedure, rectum,* has been added for 2003. Cross-references have been added to the corresponding open colectomy and open unlisted rectal procedure codes to guide users to the laparoscopic codes.

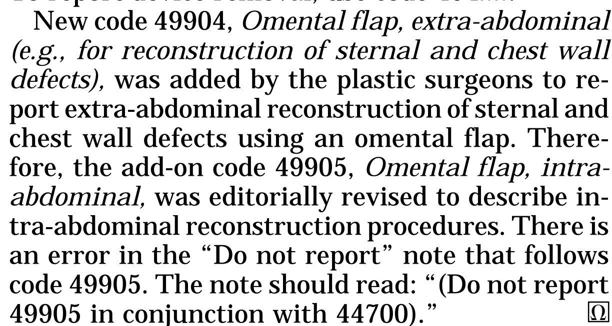
A new add-on code 44701, which describes intraoperative or on-table colonic lavage performed in conjunction with colectomy procedures, should be reported in addition to the appropriate open colectomy procedure code.

Four new codes for sigmoidoscopy and colonoscopy procedures using directed submucosal injection(s) and balloon dilation of the colon have been introduced this year. Codes 45335, *Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance,* and 45381, *Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance,* will allow reporting when a submucosal injection of substances such as India Ink, botulinum toxin, saline, and corticosteroid solutions is administered as part of a sigmoidoscopy or colonoscopy, respectively. The fact that the descriptor says "injection(s)" means that these codes may only be reported once regardless of the number of injections done. Codes 45340, *Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures,* and 45386, *Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures,* will be used to report a sigmoidoscopy or a colonoscopy with balloon dilation, respectively. Note that codes 45340 and 45386 are only reported once, regardless of the number of strictures that are dilated. Cross-references have been added to the new codes indicating that they should not be used with transendoscopic stent placement codes 45345 and 45387 because predilations are already included in the stent codes.

Code 46706 has been added to allow reporting of anal fistula repair with fibrin glue.

Peritoneum and omentum procedures

Code 49419, *Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent (i.e., totally implantable),* has been added to describe the insertion of a permanent indwelling, totally implantable catheter without external access ports. To report device removal, use code 49422.



New code 49904, *Omental flap, extra-abdominal (e.g., for reconstruction of sternal and chest wall defects),* was added by the plastic surgeons to report extra-abdominal reconstruction of sternal and chest wall defects using an omental flap. Therefore, the add-on code 49905, *Omental flap, intra-abdominal,* was editorially revised to describe intra-abdominal reconstruction procedures. There is an error in the "Do not report" note that follows code 49905. The note should read: "(Do not report 49905 in conjunction with 44700)." Ω

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