
The most important change in the *Current Procedural Terminology* (CPT) for general surgeons this year is the complete revision of central venous access procedures. This article covers that change first and then moves on to other codes in numerical procedure code order.

First, though, a reminder that the general rule for Medicare's acceptance of old codes is that carriers will accept either CPT 2003 or CPT 2004 for claims received during January, February, and March. Beginning April 1, carriers will reject procedure codes deleted in CPT 2004.

CVA procedure codes

The section containing central venous access (CVA) procedures codes (36555-36597) has been extensively rewritten and expanded to more accurately reflect the increasing variety and complexity of procedures that surgeons perform. A total of 27 codes are in the new section, including 24 new codes and three existing codes that were relocated; 10 old codes were deleted. The codes are grouped into five categories that describe inser-

tion, repair, partial replacement, complete replacement, and removal of a CVA.

The internal tip of the catheter must be within the subclavian, brachiocephalic (innominate) or iliac veins, the superior or inferior vena cava, or the right atrium to qualify as a CVA device. The actual device may be a catheter, port, or pump. The external end of the device may be either on or under the skin. The codes recognize CVA catheters that are inserted either centrally or peripherally and may be tunneled or non-tunneled. Subcutaneous ports may be implanted either centrally or peripherally, while pumps are only implanted centrally. There is no distinction related to catheter size or whether the vein entry was achieved percutaneously or by cutdown. The age distinctions for CVA devices have been raised from equal to or more than two years to equal to or more than five years; a modifier indicating that the patient was a neonate or infant up to 4 kg in weight (modifier -63) may be added to the procedure code.

Two repair codes and one partial replacement code may be used for the catheter portion of the device. Two codes apply to the removal of the entire device, and six codes indicate complete replacement of a CVA device through the same access site. If complete replacement is performed at a new site,

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CPT changes in 2004

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use the appropriate new insertion code, along with the relevant removal code for the device being replaced. When reporting the repair, replacement, or removal of a multi-catheter device, use the appropriate code to describe the procedure with a frequency of two.

The codes are summarized in Table 1 on this page. Additional versions of the table, sorted by procedure code and by device (such as insertion,

repair), are available on the College's Web site at http://www.facs.org/fellows_info/bulletin/2004/cvacodes.xls.

Vascular coding

Four new codes were added to report upper extremity arterial bypass grafts using vein. All four codes include procurement of suitable autogenous conduit, either saphenous or arm vein. Table 2 on

Table 1:
Central venous access codes by procedure

Procedure	Entry site	Device	Tunneled	Age	Example	Code
Insertion	Extremity	Catheter		< 5	PICC	36568
Insertion	Extremity	Catheter		> = 5	PICC	36569
Insertion	Extremity	Port		< 5		36570
Insertion	Extremity	Port		> = 5		36571
Insertion	Torso	Catheter	No	< 5		36555
Insertion	Torso	Catheter	No	> = 5		36556
Insertion	Torso	Catheter	Yes	< 5		36557
Insertion	Torso	Catheter	Yes	> = 5		36558
Insertion	Torso	Port	Yes	< 5		36560
Insertion	Torso	Port	Yes	> = 5		36561
Insertion	Torso	Pump	Yes			36563
Insertion	Torso	Dual catheter	Yes		Tesio-Type	36565
Insertion	Torso	Port w/ 2 catheters	Yes			36566
Repair	Extremity	Catheter				36575
Repair	Torso	Catheter				36575
Repair	Extremity	Port/pump				36576
Repair	Torso	Port/pump				36576
Replace catheter	Extremity	Port/pump				36578
Replace catheter	Torso	Port/pump				36578
Complete replacement	Extremity	Catheter			PICC	36584
Complete replacement	Extremity	Port				36585
Complete replacement	Torso	Catheter	No			36580
Complete replacement	Torso	Catheter	Yes			36581
Complete replacement	Torso	Port	Yes			36582
Complete replacement	Torso	Pump	Yes			36583
Removal	Extremity	Port/pump	Yes			36590
Removal	Torso	Catheter	Yes			36589
Removal	Torso	Port/pump	Yes			36590

this page provides an overview of the four new codes.

A new code has been established to report an elective open bypass graft and ligation procedure for patients suffering from steal syndrome related to hemodialysis access. It is code 36838, *Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)*.

A new add-on code has been created for reporting reimplantation of the visceral artery (that is, inferior mesenteric, accessory renal) during either aortic aneurysm repairs or aortic bypass procedures. Code 35697, *Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery*, is reported one time for each infrarenal artery reimplanted during the procedure. There is a cross-reference directing the reader *not* to report code 35697 with code 33877, *Repair of thoracoabdominal aortic aneurysm*, since all subsequent infrarenal implantations are included in code 33877.

An existing category III CPT code for reporting aorto-uniiliac or aorto-unifemoral endovascular repair of an infrarenal abdominal aortic aneurysm or dissection has been converted to a category I code. It is code 34805, *Endovascular repair of an infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis*. A note indicates it is permissible to report open arterial exposure (for example, codes 34812 or 34820) with code 34805. In addition, all introductory remarks related to the endovascular aortic aneurysm repair family of codes, as well as rules related to component coding, are relevant when reporting code 34805.

There is a new note after code 35572, *Harvest of femoropopliteal vein, one segment, for vascular reconstruction procedure*, indicating that modifier -50 should be used when performing this procedure bilaterally.

Two new codes were created to report stab phlebectomy of varicose veins. Code 37765, *Stab phlebectomy of varicose veins, one extremity; up to and including 20 incisions*, is used to report 10 to 20 stab incisions in one leg. Code 37766 is used to report more than 20 stab incisions in one leg. The unlisted vascular surgery service code 37799 should be used to report this service when fewer than 10 stab incisions are performed.

Table 2:

New venous bypass graft codes

Code	Bypass graft
35510	Carotid-brachial
35512	Subclavian-brachial
35522	Axillary-brachial
35525	Brachial-brachial

Gastric tube placement

Code 43752 has been revised to clarify that the code is to be reported only in those rare instances when a physician performs naso- or orogastric tube placement under radiologic guidance. The language specifies that the service includes fluoroscopic guidance, consisting of fluoroscopy, image documentation, and a report.

Living donor hepatectomies

To reflect the growing sophistication of living donor hepatectomies, three new codes have been added to report the removal of different portions of the liver. These include code 47140 to report the removal of the left lateral segment (segments II and III), code 47141 to report a total left lobectomy (segments II, III, and IV), and code 47142 to report a total right lobectomy (segments V, VI, VII, and VIII).

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Code 47134, the old code for a partial lobectomy from a living donor, has been deleted. There is a cross-reference directing that all hepatectomies that were reported using code 47134 be reported using code 47140. That is certainly true for partial left lobectomies, but it is not true for total right or total left lobectomies. Full or formal (“total”) lobectomies should be reported as code 47141 or 47142.

Starred procedures


You will remember that several surgical procedures (such as code 47000, *Biopsy of liver; needle; percutaneous*, and code 46500, *Injection of sclerosing solution, hemorrhoids*) had a star or an asterisk next to them. The star meant that the service included only the surgical procedure; pre- and post-operative services, including complications, were reported separately.

The stars have become obsolete due to the recognition of zero and 10-day global services and the creation of a modifier for a significant, separately identifiable evaluation and management (E/M) service on the same day as a procedure (modifier -25). Therefore, the stars are being deleted, but, of course, the procedure will remain. Code 99025, for a visit by a new patient at the time a starred procedure is performed, also was deleted. One of the usual E/M services should be reported if necessary.

Category II and III

CPT has added category II codes for performance measurement this year. They represent activities that normally are carried out as part of an E/M service and are widely believed to indicate high-quality care if performed on eligible patients. Examples are blood pressure measurement and the prescription of beta blockers. Because these codes are a part of an E/M service, they do not have assigned relative values. However, in the near future, some payors may begin using these codes to pay an incentive for high-quality performance over the course of a year. The category II codes appear after the end of the category I codes. Presently, none of the measures applies to surgery.

Surgeons are expected to be familiar with and use category III codes when the procedure they perform is described by one of these codes. The category III designation is assigned for emerging

technology procedures or for procedures involving devices that are not yet approved by the Food and Drug Administration (FDA). Once a device gains FDA approval, conversion to a category I CPT code requires a minimum of 15 months, but the category III designation is maintained throughout that interval of time. For the Medicare program, decisions about coverage for category III codes, and a determination of the payment amount for most category III codes, have been delegated by the Centers for Medicare & Medicaid Services to the local carriers. Surgeons should discuss coverage and, if necessary, the payment amount with their carriers in advance of performing the procedures if they believe payment is indicated. This year, codes 0045T-0061T have been added. Breast, thoracic, and orthopaedic surgeons should review the new codes. 

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