

# CPT

## Current Procedural Terminology:

## Changes for 2006

by **Albert Bothe, Jr., MD, FACS,**  
**Chicago, IL,**

and **Jean A. Harris, Associate Director,**  
**Division of Advocacy and Health Policy, Washington, DC**

**T**his article contains a summary of changes in the 2006 *Current Procedural Terminology* (CPT)\* that are relevant to general surgery and closely related specialties. Remember that this article may be useful to others in the office who perform coding functions. The changes are discussed in code sequence.

### ***Necrotizing soft tissue infection***

A note has been added after code +11008, *Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection*, stating that code 49568 is to be used when mesh is inserted for closure following debridement of necrotizing soft tissue infection. However, no change has been made to the descriptor of code 49568, *Implantation of mesh or other prosthesis for incisional or other ventral hernia repair*. Consider making a notation in your book by code 49568 that it is to be used for such a closure and cross-reference that wording to the note after code +11008. That way, you will remember where you found the language in the event of an audit.

### ***Skin replacement surgery***

The section that was headed "Free Skin Grafts" in earlier editions of the CPT is now headed "Skin Replacement Surgery and Skin Substitutes"; it contains new notes on using the codes and a substantial number of new codes. Codes were added for autografts/tissue-cultured autografts, acellular dermal replacements, allograft/tissue-cultured allogeneic skin substitutes, and xenografts. Codes for application of bilaminar skin substitutes and allografts have been deleted.

Among other things, the notes tell the reader

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to separately report the surgical preparation and type of skin graft or skin substitute. The initial wound site preparation is reported either by code(s) 15000-15001 or the primary procedure (for example, radical mastectomy). Code 15000 is *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or one percent of body area of infants and children*, and code +15001 is for each additional 100 sq cm or one percent of body area of infants or children. Note that language "or incisional release of scar contracture" was added to both codes.

The last paragraph of the new note says the codes in this section are not to be reported unless the skin graft or substitute is surgically anchored in place. Sutures and staples have traditionally been used and, as time went on, surgical techniques included such things as fibrin glues and steri-strips. More recently, skin substitutes have come to market that require no wrapping or a simple gauze wrap. It is in those situations, where no surgical anchoring is done, that the codes in this section are not to be used.

The last two sentences of the paragraph of the notes should read, "When any grafting services are performed in the office, the supply of skin substitute/graft should be reported separately. Routine dressing supplies are not reported separately." The note that appears in the book omits the phrase, "any grafting."

### ***Vascular procedures***

The seven Category III codes (0033T-0049T) for reporting placement of an endovascular graft for the repair of the descending thoracic aorta have been moved to Category I codes (33880-33891). However, the codes have additional language in

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the descriptor and extensive introductory language has been added, explaining what the codes include and what may be separately reported. Codes 34833 and 34834, for open iliac and brachial artery exposure, have been modified to allow them to be used for endovascular repair of the thoracic aorta.

A new code, 36598, *Contrast injection(s) for radiologic evaluation of existing central venous access device including fluoroscopy, image documentation and report*, has been established to report the evaluation of the position and function of an existing catheter. The procedure includes removal of any obstructive material, so notes direct the user not to report code 36598 with codes 36595 or 36596, removal of pericatheter or intracatheter obstructive material.

Codes 37184-37188 were added for mechanical arterial and venous thrombectomy in peripheral vessels. The new material also includes extensive notes explaining what is included in the codes and what may be reported separately. The new codes have a bull's eye symbol in front of them, meaning the code includes moderate, or conscious, sedation. Code 37209 has been modified to permit its use for both venous and arterial catheter exchange during thrombolytic therapy. It previously was limited to arterial catheter exchange.

Finally, code 37718, *Ligation, division, and stripping, short saphenous vein*, and code 37722, *Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below*, were added. There are notes saying do not report codes 37718 or 37722 with each other or with the existing code 37700, *Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions*. There is a similar note under existing code 37735, *Ligation and division and complete stripping of long or short saphenous veins of lower leg, with radical excision of ulcer and skin graft and/or interruption of communication veins of lower leg, with excision of deep fascia*. That note says not to report code 37735 with codes 37700, 37718, 37722, and 37780. The descriptor for code 37780 is *Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)*.

### **Bariatric surgery**

Code 43770 was added for laparoscopic placement of an adjustable gastric band and subcutaneous port. Codes were also added for laparoscopic

revision (code 43771), removal (code 43772), and removal and replacement (code 43773) of the adjustable gastric band component only. Laparoscopic removal of both the adjustable gastric band and subcutaneous port is covered by code 43774. There are notes that say to report code 43770 with a -52 modifier, meaning a reduced service was performed, when only one component is replaced and report the unlisted gastric laparoscopic code (43659) when removal and replacement of both components is performed. A note explains that code 43770 includes any band adjustments throughout the postoperative period.

A revision was made to code 43848, for an open revision of a gastric restrictive procedure, to limit its application to gastric restrictive procedures other than adjustable gastric banding. Three new codes were added for open revision, removal, and removal and replacement of subcutaneous port only (codes 43886-43888).

### **Intestine, rectum, and anus procedures**

A group of four new laparoscopic codes (44180-44188) were added for enterolysis, jejunostomy for decompression or feeding, non-tube ileostomy or jejunostomy, and colostomy or skin level cecostomy. Note that the code for enterolysis has the phrase "separate procedure" as part of the descriptor. The proper way to report extensive enterolysis when performed with another procedure is to report the primary procedure with modifier -22, which indicates an unusual procedural service was done. Your payor will probably want a copy of the operative note and perhaps a letter explaining how much more work was involved.

A laparoscopic add-on code (44213) was established for mobilization of the splenic flexure performed in conjunction with a partial colectomy. A laparoscopic repair code (44227) was added for closure of an enterostomy, with resection and anastomosis, in either the large or small intestine.

The phrase "separate procedure" was removed from code 44310, *Ileostomy or jejunostomy, non-tube*, and 44320, *Colostomy or skin level cecostomy*, and replaced with notes telling CPT users not to report 44310 and 44320 with certain specified codes.

Code 45395 was added for a complete abdominoperineal proctectomy with colostomy performed

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laparoscopically. Code 45397 was added for laparoscopic proctectomy with a colo-anal anastomosis and creation of a colonic reservoir. The code also includes a diverting enterostomy if performed. A code was added for a laparoscopic proctopexy (code 45400) and another was added for a laparoscopic proctopexy with sigmoid resection (code 45402). There is a new unlisted laparoscopy procedure code for the rectum (code 45499). Finally, a code was added for a diagnostic anorectal examination requiring general, spinal, or epidural anesthesia (code 45990). There is a note informing CPT users not to report code 45990 with certain other procedures.

Code 46505 was created to report chemodeneration of the internal anal sphincter. Two codes were added to report the pouch advancement of an ileoanal pouch fistula or sinus. They are code 46710, which uses a transperineal approach, and code 46712, which uses a combined transperineal and transabdominal approach.

### **Category II codes**

Category II codes, which were introduced in 2004, provided a way for reporting and tracking performance through a payor's claims-processing system. These are not traditional procedure codes—they are codes that give clinical data and are reported in addition to the procedure that was performed. The codes do not have relative values attached to them, their use is optional, and they may not be used in place of Category I codes. They are in the form of four digits followed by the letter "F." Examples are 1000F, *Tobacco use, smoking, assessed*; 1002F, *Anginal symptoms and level of activity, assessed*; and 2000F, *Blood pressure measured*.

In the 2006 CPT, the Category II section is much more robust than it has been previously, having gone from two diseases with 14 measures to six diseases with three dozen measures. Equally important is the addition of two modifiers that say the measure was considered but, because of medical or patient circumstances that are documented in the medical record, was not provided.

The codes are listed in full by type of service in the section of the CPT labeled Category II codes. In Appendix H, the measures are grouped by disease and more information is given about how they will be used. Each measure has a defined

numerator and denominator that, when the division is done, represent the percentage of patients for whom the service was provided.

It is important that category codes be well understood by all physicians, including surgeons, if a payor in your area begins a pay for performance plan. It would not be surprising if some payors begin using the coronary artery disease measurements for patients who receive surgical treatment of the disease. Likewise, payors could request an orthopaedic surgeon treating osteoarthritis, either surgically or medically, to use the osteoarthritis measures.

The Centers for Medicare & Medicaid Services has established a series of "G" codes that it is using in a similar voluntary reporting program beginning January 3, 2006. A future *Bulletin* article will provide more detailed information about this program.

### **Category III codes**

Code 0120T, *Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma* and Code 0133T, *Upper gastrointestinal endoscopy, including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with injection of implant material into and along the muscle of the lower esophageal sphincter (eg, for treatment of gastroesophageal reflux disease)* have been added. Remember that if a Category III code exists for a procedure, it must be used instead of a Category I unlisted code. Ω

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*Dr. Bothe is associate dean and executive director, University of Chicago practice plan, Chicago, IL.*

