Current Procedural Terminology: CPT Changes for 2008

by Albert Bothe, Jr., MD, FACS

This article summarizes changes in the 2008 Current Procedural Terminology (CPT)* that are relevant to general surgery and closely related specialties. This information should be useful not only to surgeons but also to office staff who perform coding functions.

Multiple procedure changes

Three codes have been added to the multiple procedure rules. More specifically, two codes became subject to the multiple procedure rules, and one code became an add-on code. The multiple procedure rules require that modifier –51 be appended to the code and reimbursement is generally reduced. (Medicare does not require the –51 modifier be appended but does reduce payment by 50 percent.) Code 35600, *Harvest of upper extremity artery, one segment, for coronary artery bypass procedure*, became an add-on code because it is always performed in conjunction with the coronary artery bypass codes (codes 33533–33536). Code 36660, *Catheterization, umbilical artery, newborn, for diagnosis or therapy*, is no longer a modifier –51-exempt code because it involves significant work before and after the procedure. Modifier –51-exempt codes do not have significant service time for before and after the procedure associated with them and, therefore, it is unreasonable to reduce payment for them. Code 38792, *Injection procedure; for identification of sentinel node*, has been removed from the modifier –51-exempt list in part because Medicare already treats the code as subject to the modifier –51 rules.

Excision and repair of skin lesions

Notes have been added to the sections on excision of benign and malignant skin lesions (codes 11400–11646) and adjacent tissue transfer (codes 14000–14061) to clarify that excision of the lesion is not separately reported when an adjacent tissue transfer is performed.

Vascular procedures

The code for transcatheter placement of a wireless physiologic sensor in an aneurysmal sac during an endovascular repair was moved from category III (code 0153T) to category I (code 34806). A new code 35523 was established to report a brachial-ulnar or brachial-radial bypass

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graft with vein. A note was added after existing code 36838, *Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)*, telling users not to report code 36838 with code 35523.

Central venous access procedures

Three new codes related to central venous access procedures were established and two codes were assigned new numbers. The new codes are code 36592, *Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified;* code 36595, *Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access;* and code 36596, *Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen*. Code 36540, *Collection of blood specimen from a completely implantable venous access device*, was reassigned to be code 36591, and code 36550, *Declotting by thrombolytic agent of implanted vascular device or catheter*, was changed to code 36593. Notes were added directing users not to report codes 36591 or 36592 with any other service and not to report code 36595 or 36596 with code 36593.

Choledochal cysts

Code 47719, *Anastomosis, choledochal cyst, without excision*, has been deleted because the procedure was never done. According to *CPT Changes: An Insider's View 2008,* published by the American Medical Association, it is appropriate to report code 47715, *Excision of choledochal cyst*, in those cases where the cyst cannot be completely removed.

Retroperitoneal tumors

Three new codes have been established for reporting the excision of retroperitoneal tumors, differentiated by the size of the tumor. If more than one tumor is removed or destroyed, the code for the largest tumor is reported. All three codes contain the language *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors.* Code 49203 is used when the largest tumor is 5 cm diameter or less; code 49204 is used when the largest tumor is 5.1 to 10.0 cm in diameter; and code 49405 is used when the largest tumor is greater than 10.0 cm in diameter. Codes 49200 and 49201, which were for the simple and extensive excision or destruction of intraabdominal or retroperitoneal tumors or cysts or endometriomas, were deleted.

G-, D-, J-, G-J-, and C-tubes

The Figure on page 20 shows all of the new and existing codes in CPT to report an array of services regarding percutaneous gastrointestinal tubes, including many that are frequently performed by specialties other than general surgeons. Code 43750, *Percutaneous placement of gastrostomy tube*, has been deleted; a note directs users to existing code 43246, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube*, for percutaneous insertion of a gastrostomy tube that does not require imaging guidance. Existing code 43761, for repositioning the gastric feeding tube through the duodenum, was modified by removing "any method" to avoid confusion with other codes.

Expanded use of abdominal mesh

The codes for the implantation and removal of abdominal mesh—codes 49568 and 11008, respectively—have been revised to permit reporting the mesh for closure of debridement for infection. The codes, which are add-on codes, had previously been limited to use in incisional and ventral hernia repair.

Aspiration of thyroid cyst

Code 60001, *Aspiration and/or injection, thyroid cyst*, has been moved to 60300.

Evaluation and management codes

The evaluation and management (E/M) section of the CPT contains a number of new codes of potential interest to surgeons. It is essential that coders meet all of the administrative requirements of the codes and provide complete documentation of the services furnished in the medical record. If insurers pay for these codes, they doubtless will be interested in performing post-payment reviews of the use of these codes.

Figure. Codes for reporting various procedures involving tubes in the gastrointestinal tract

Code number	Descriptor	Status of code
43246	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube	Existing
43752	Nasogastric or orogastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation, and report)	Existing
43760	Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance	Modified
43761	Repositioning of the gastric feeding tube, through the duodenum for enteric nutrition	Modified
49440	Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report	New
49441	Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report	New
49442	Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report	New
49446	Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report	New
49450	Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report	New
49451	Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report	New
49452	Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	New
49460	Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed, image documentation, and report	New
49465	Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation, and report	New
75984	Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision, and interpretation	Modified

New codes are replacing the old codes for medical team conferences. Code 99367 is used to report a physician's participation in a medical team conference when the patient or family is not present. (Code 99368 is for use by nonphysicians.) The conference may include a minimum of three health care professionals from different specialties, with no more than one individual from the same specialty. Each participant must have treated or evaluated the patient within the previous 60 days and each must document what he or she contributed to the discussion and the treatment recommendations made as a result of the conference. If also reported, the care plan oversight codes (codes 99374–99380) must account for separate time. Conferences lasting less than 30 minutes are not separately reported.

For team conferences with the patient and/or family present, physicians should use the regular E/M codes for the site where the team conference takes place. Existing reporting instructions say that when counseling and/or coordination of care accounts for at least 50 percent of the time of the visit, then time is the controlling factor and is used to decide which code to report. The extent of counseling or coordination of care must be documented in the medical record. Code 99366 has been established for a nonphysician health care professional to report his or her participation in the conference. The rules for the nonphysician's participation are the same as when the patient or family is not present, as discussed previously.

Two codes have been added for a structured screening and brief intervention service related to alcohol and other substance abuse. Code 99408 is for *Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes;* code 99409 has the same descriptor but is for more than 30 minutes. Services of less than 15 minutes are not separately reported. These codes are used to report the SBI that must be available at level I trauma centers. Either a physician or a qualified nonphysician health care professional may report these codes.

Codes have been established for reporting telephone calls initiated by an established patient. Code 99441 is for reporting five to 10 minutes of discussion, code 99442 is for 11 to 20 minutes of discussion, and code 99443 is for 21 to 30 minutes of discussion. These codes are not to be used to report a telephone call made if the patient is within the postoperative period of a recent procedure or received a related E/M service within the previous seven days or if the telephone call results in seeing the patient within the next 24 hours or next available urgent appointment.

Code 99444 has been established for an online E/M service provided by a physician using the Internet. However, the code is not to be used if the patient has had a related E/M service in the previous seven days or is within the postoperative period of a recent procedure. Ω

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