



# CPT Changes 2012

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# 537 Changes for 2012

- 278 new
- 139 revised
- 98 deleted
- 22 re-sequenced

# Changes to instructions for use of the CPT manual

- Clarification defining “other healthcare professional” as different from “clinical staff” – page x of CPT introduction

# E/M guidelines

- Guidelines changes for new patients have added wording to indicate that a new patient “has not received services from of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years”

# E/M Observation

- Times have been added to hospital observation care to standardize format with other E/M codes:
  - 99128 – 30 minutes
  - 99219 – 50 minutes
  - 99220 – 70 minutes

# E/M Prolonged Services

- Clarified to better define “direct” patient contact includes floor/unit criteria for in-patient services

# E/M Pediatric Critical Care Patient Transport

- New codes for hypothermia procedures for neonates, cross referenced but not bundled in
- 0260T – total body, per day, 28 days or younger
- 0261T – selective head, per day, 28 days or younger

# E/M Inpatient Neonatal & Pediatric Critical Care

- Guidelines revised to match other critical care
- Services bundled in revised to include new car seat evaluation codes 94780, 94781
- Clarification of rules for transfer from physician to physician on same day

# E/M Initial & Continuing Intensive Care Services

- Clarification of rules for transfer from physician to physician on same day
- Transfer to lower level of care requires “subsequent” care code, broken out by weight of patient \*

# Surgery

- 60 new codes
- 86 revised codes
- 48 deleted codes

# Integumentary

- 11975 & 11977, implantable contraceptive codes, deleted due to non-use, CPT re-directs to 11976 & 11981

# Integumentary

- Repair notes have been revised to require modifier 59 instead of modifier 51 in #2 & 4 of the instructions

# Integumentary/ Skin Replacement Surgery

- Skin replacement surgery notes have been revised to clarify age 10 as the boundary for percentages of body areas affected
- 8 new codes, 6 revised, 24 deleted to make section more consistent

# Integumentary/ Skin Replacement Surgery

- New notes clarify that grafts and implants are separate from primary procedure, report in addition
- Notes also define non-autologous, non-human, and biologic products as skin substitutes

# Integumentary/Autografts

- Codes 15150 – 15157 revised to reflect changes in notes to “skin substitute” rather than “epidermal, acellular, etc.
- Codes 15170 – 15176 deleted for same reason

# Integumentary/ Skin substitute grafts

- New codes 15271, 15272, 15275, & 15276 describe area up to 100 sq. cm
- New codes 15273, 15274, 15277, & 15278 describe area equal or greater than 100 sq. cm

# Integumentary/Other Flaps & Grafts

- New add-on code 15777 to report biologic implant for soft tissue reinforcement in addition to primary Procedure
- seven cross reference notes added to aid selection of this and/or new skin substitute codes

# Musculoskeletal

- 2 new codes added for treatment of Dupuytren's contracture:
- 20527 for enzyme injection
- 26341 for palmar fascial cord manipulation

# Musculoskeletal/vertebral body,...

- Codes 22520, 22521, 22522 revised to include bone biopsy when performed with percutaneous vertebroplasty

new parenthetical note excludes using these codes with other bone biopsy & vertebroplasty codes 20225, 22310-22315, 22325, 22327 at the same level

# Musculoskeletal/Arthrodesis

- Codes 22610 & 22612 revised to include lateral transverse technique when performed
- Codes 22633 & 22634 added for combined arthrodesis and laminectomy
- New note, do not report 22612 & 22630 at the same level

# Musculoskeletal/Pelvis/Hip

- Code 27096, sacroiliac injection, revised to include image guidance (CT or fluoroscopy) when performed

New parenthetical note states 20552 should be used if imaging not performed

# Musculoskeletal/Casts

- Code 29581 revised & codes 29582, 29583, 29584 added to report multilayer compression system application – now divided out by upper/lower leg and upper/lower arm

# Musculoskeletal/Arthroscopy

- Code 29826, decompression of subacromial space with partial acromioplasty revised to become add-on code

# Musculoskeletal/Arthroscopy

- Codes 29880 & 29881 surgical arthroscopy of knee, revised to include chondroplasty when performed

# Respiratory/Lungs & Pleura

- New notes for this section due to new procedure definitions and instructions, and also new notes to instruct when to code more extensive procedures

# Respiratory/Lungs & Pleura

- New codes 32096, 32097, & 32098 added for thoracotomies with biopsy, along with new notes for reporting wound exploration due to trauma without thoracotomy

Can only be reported once per lung

# Respiratory/Lungs & Pleura

- Codes 32100, 32110, 32120, 32142, 32140, 32141, 32150, 32151, 32160, all revised to remove “biopsy” due to addition of new codes above
- 32140 & 32141 also revised to include pleural procedure when performed

# Respiratory/Lungs & Pleura

- Code 32405 revised to add symbol for conscious sedation included in procedure

New parenthetical notes direct to new/revised excision codes here

# Respiratory/Lungs & Pleura

- Codes 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491 for lung removal all revised to remove “total” due to new, more extensive codes added this year

# Respiratory/Lungs & Pleura

- New codes 32505, 32506, & 32507 added for wedge resection:
- 32505 therapeutic, initial
- 32506 therapeutic, additional (add-on)
- 32507 diagnostic, followed by anatomic (add-on)

# Respiratory/Lungs & Pleura

- Thoracoscopy sub-section has new note indicating more specific terminology is “video assisted thoracic surgery (VATS)”
- Code 3260, diagnostic thoracoscopy, revised to include “pericardial sac” & “mediastinal”

# Respiratory/Lungs & Pleura

- New codes 32607, 32608, & 32609 added to report thoracoscopic biopsy procedures

32602, 32603, & 32605 deleted due to new procedures above

Report new codes once per lung

# Respiratory/Lungs & Pleura

- Code 32655, surgical thoracoscopy, revised to add “resection” of bullae and to include any pleural procedure when performed
- Code 32663, thoracoscopic lobectomy, revised to delete “total” due to new codes

# Respiratory/Lungs & Pleura

- 9 other new codes added to thoracoscopy section:
- 32666, wedge resection
- 32667, each addition wedge (add-on)
- 32668, diagnostic wedge followed by anatomic wedge (add-on)

# Respiratory/Lungs & Pleura

- 32669, with segmentectomy
- 32670, with bilobectomy
- 32671, with pneumonectomy
- 32672, with resection for emphysematous lung, for lung volume reduction, unilateral, includes any pleural procedure when performed

# Respiratory/Lungs & Pleura

- 32673, with resection of thymus
- 32674, with mediastinal & regional lymphadenectomy (add-on)

# Cardiovascular/Pacemaker

- Many new notes to explain differences between pacemakers and pacing cardioverter/defibrillators
- New table on CPT page 171 to show codes for pacemaker vs. cardioverter/defibrillator

# Cardiovascular/Pacemaker

- Codes 33206, 33207, 33208 revised to clarify insertion of new or replacement
- Codes 33212, 33213 revised for insertion of pulse generator, “replacement” removed, also now specify single or dual leads
- New code 33221 for pulse generator, multiple leads – out of sequence

# Cardiovascular/Pacemaker

- Codes 33218 & 33220, repair of transvenous electrodes, revised to remove reference to number of chambers involved
- Code 33224, insertion of pacing electrode, revised to include removal, insertion, and/or replacement

# Cardiovascular/Pacemaker

- Code 33225, add-on pacing electrode at time of insertion of pacing cardioverter, revised to include pocket revision
- Code 33226, repositioning, revised to include removal, insertion, and/or replacement of existing generator
- Code 33233, removal of generator, revised, now for removal only

# Cardiovascular/Pacemaker

- New codes 33227, 33228, & 33229 added for removal with replacement of permanent pacemaker, individual codes specify single, dual, or multiple lead
- New codes 33262, 33263, 33264 added for removal with replacement of permanent pacing cardioverter- defibrillator, individual codes specify leads

# Cardiovascular/Pacemaker

- Codes 33240 revised, and codes 33230 & 33231 added, to give individual codes for insertions of pacing cardioverter/defibrillator with single, dual, or multiple leads
- Code 33241 revised for removal only of cardioverter-defibrillator

# Cardiovascular/Pacemaker

- Code 33249, insertion/replacement of pacing cardioverter-defibrillator revised, no longer includes repositioning

# Cardiovascular/Cardiac Assist

- Notes revised to identify applicable code ranges
- Codes 33960 & 33961, prolonged extracorporeal circulation, revised to read “day” instead of “24 hours”

# Cardiovascular/Arteries & Veins

- Revised to add conscious sedation symbol:
- Codes 36200, introduction of aortic catheter
- Codes 36245, 36246, 36247, 36248, selective catheter placement, arterial

# Cardiovascular/Arteries & Veins

- New codes added to combine renal catheterization & angiography:
- 36251 & 36252 for selective renal catheter & angiography, unilateral & bilateral
- 36253 & 36254 for superselective renal catheter & angiography, unilateral & bilateral

# Cardiovascular/Arteries & Veins

- 3 new codes added for intravascular vena cava filter, endovascular approach:
- 37191 – insertion
- 37192 – repositioning
- 37193 - retrieval

# Hemic/Lymphatic

- Codes 38208 & 38209, transplant preparation of hematopoietic progenitor cells; thawing... revised to state “per donor”
- Code 38230, bone marrow harvesting, revised to state “allogenic”
- New code 38232, bone marrow harvesting, autologous, added

# Hemic/Lymphatic

- Code 38746, thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy, add-on, revised to better identify location of node resections and intended use

# Hemic/Lymphatic

- Code 38792, injection procedure for sentinel node, revised to include “radioactive tracer” to clarify and differentiate from 38900 which uses non-radioactive dye

# Mediastinum & Diaphragm

- Codes 39200 & 39220, excisions of mediastinal cyst & tumor, revised to add “resection” to clarify intended use
- Code 39400, mediastinoscopy, revised to “include biopsy when performed”

# Digestive/Liver

- Code 47000, biopsy of liver, needle; percutaneous, revised to include conscious sedation symbol

# Digestive/Abdomen

- New codes 49082 & 49083, abdominal paracentesis with & without imaging
- New code 49084, peritoneal lavage with imaging guidance when performed

Both added to replace deleted codes 49080 & 49081 which bundled the 2 procedures

# Nervous system

- Code 62287, percutaneous decompression of nucleus pulposus of intervertebral disc, revised to clarify its use of **indirect** visualization

# Nervous system

- Codes 62310 & 62311 spinal anesthesia injections by region and
- Codes 62318 & 62319, spinal anesthesia injections including catheter by region

Revised to clarify reporting as single injection, by region – codes should be reported once Nervous system

# Nervous system

- Code 62367, electronic analysis of programmable, implanted pump, revised to remove programming & refill
- New codes 62369 & 62370, electronic analysis of programmable, implanted pump, added to report with reprogramming & refill, with and without requiring physicians skill

# Nervous system

- Codes 63020, 63030, & 63035, laminotomy with decompression codes revised to remove wording indicating open & endoscopically assisted approach included – new notes indicate that endoscopic assisted procedures require open & direct visualization. Endoscope only procedures reported with 0274T & 0275T

# Nervous system

- Neurostimulator codes revised to better define procedures & clarify use. Revised codes are 64553, 64555, 64561, 64565, 64575, 64580, 64581, 64585

# Nervous system

- Destruction by neurolytic agent codes 64622-64627 codes deleted, replaced by new codes 64633-64636. Replacement due to change in reporting from vertebral level to number of facet joints treated at each vertebral level. The number of nerves injected does not affect code selection.

# Radiology

- Codes 72114 & 72120, exam of spine, lumbosacral, revised to report number of views
- New code 74174, CTA abdomen & pelvis added to reflect frequency of performing these studies together

# Radiology

- New codes 77424 & 77425 for intraoperative radiation treatment delivery (x-ray or electrons), added to allow for newer equipment & treatment options
- New code 77469 added for intraoperative radiation treatment management

# Radiology

- New codes 78226 & 78227 added for hepatobiliary system imaging, including gallbladder when present, with and without pharmacologic intervention

# Radiology

- New codes 78579, 78582, 78597, & 78598 added to clarify that procedures must be reported by type of testing rather than according to type of product
- Code 78580 revised due to the same guideline

# Pathology & laboratory

- Addition of new subsection for Molecular pathology added, includes 2 subsections (Tier 1 and Tier 2) and 101 new codes

# Pathology & laboratory

- “Molecular pathology procedures are medical laboratory procedures involving the analysis of nucleic acid to detect variants in genes that may be indicative of germline (eg. constitutional disorders) or somatic (eg. neoplasia) conditions, or to test for histocompatibility antigens (eg. HLA).”

# Pathology & laboratory

- Molecular pathology, Tier 1, is for gene-specific and genomic procedures, and contains 92 new codes, 81200-81383
- Molecular pathology, Tier 2, is for molecular pathology procedures not listed in Tier 1, contains 9 new codes, 81400-81408

# Pathology & laboratory

- Examples of gene specific codes include breast cancer, cystic fibrosis, fragile X, etc., some with notes describing target population
- Main term to locate individual tests is “gene analysis”

# Pathology & laboratory

- New code in Immunology, 86386, to specifically identify nuclear matrix protein 22 (NMP22) – previously reported but not specified in code 86294

# Pathology & laboratory

- Code 86703, HIV-1 & HIV-2, revised to read “single result” instead of “single assay”
- New code 87389, HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result added

# Pathology & laboratory

- Codes 88312, 88313, 88314, & 88319 for special stains revised to better define special stains and add new instructions and parenthetical notes

# Medicine

- Code 90460, Immunization admin, has been revised to clarify it can only be reported once per day
- Code 90581, anthrax vaccine, revised to include IM route

# Medicine

- New code 90654, flu vaccine, added to include intradermal use
- Code 90663, H1N1 vaccine, deleted – vaccine no longer offered – seasonal flu vaccine incorporates H1N1 virus

# Medicine/Psychiatry

- Coded 90867 & 90868, Therapeutic repetitive TMS, initial and subsequent, revised to include new code, 90869, for subsequent motor threshold re-determination delivery & management

# Medicine/Gastroenterology

- Codes 91010 & 91013, esophageal motility study, revised to remove language specifying two-dimensional or three-dimensional, done in both Medicine & Category III sections (for codes 0240T & 0241T)

# Medicine/Ophthalmology

- New codes 92071 & 92072, fitting of contact lens for treatment of ocular surface disease or management of keratoconus added, and 92070 deleted, due to 2 distinct uses for previous 92070 that needed to be separated out

# Medicine/ Otorhinolaryngologic

- New code 92558, evoked otoacoustic emission screening added and
- Codes 92587 & 92588, distortion product evoked product otoacoustic emissions, 3-6 frequencies or minimum of 12 frequencies revised to clarify use and intent

# Medicine/ Otorhinolaryngologic

- Code 92605, evaluation for prescription of non-speech-generating augmentative & alternative communication device, revised and
- New code 92618 added to include time – 92605 for first hour and 92618 for each additional 30 minutes

# Medicine/ Otorhinolaryngologic

- Code 92621, each additional 15 minutes of central auditory function evaluation revised to show add-on symbol

# Medicine/Cardiovascular

- New notes to clarify how to report professional services for cardiac cath
- New Tables of Catheterization Codes on CPT pages 493-495

# Medicine/Cardiovascular

- New subsection under “Noninvasive Vascular Studies” added:
- “Other Noninvasive Vascular Diagnostic Studies” – has only 1 code, 93998, for unlisted study, added due to new Category III code 0286T, near infrared spectroscopy studies

# Medicine/Pulmonary

- New notes & codes to combine procedures performed together:
- New code 94726, plethysmography for lung volume with airway resistance if performed
- New code 94727, gas dilution for lung volume with distribution of ventilation & closing volumes if performed

# Medicine/Pulmonary

- New code 94728, airway resistance by impulse oscillometry
- New code 94729, add-on, diffusing capacity
- New code 94780, car seat/bed airway testing, neonate, 60 minutes
- New code 94781, add-on, each additional **full** 30 minutes

# Medicine/Neurology

- Sleep “Medicine” Testing notes all new with definitions, explanations of procedures, and instructions for code use
- EMG has 3 new, add-on codes:
- 95885 & 95886, needle EMG, each extremity with related paraspinal areas if performed, and
- 95887, needle EMG, non-extremity

# Medicine/Neurology

- Evoked potentials & reflex tests has new code 95939 for central motor evoked potential study in upper and lower limbs combined (still has just upper or lower, if needed)

# Medicine/Neurology

- Neurostimulators, Analysis Programming revised codes 95970-95975 to clarify “simple” versus “complex” in the code descriptions
- Codes 95990 & 95991, refilling & maintenance of implantable pump, with & without physicians skill, revised to include electronic analysis

# Medicine/Therapeutic inj

- Code 96367, additional sequential infusion, revised to clarify “new drug/substance”

# Medicine/Special Services

- Notes for this section revised to report that modifier 51 should not be appended to 99050-99060 (Services provided...)

## Category II

- 59 new codes, 3 revised codes, and new & revised clinical conditions, including:
- Level of activity
- Advance care planning
- Asthma impairment/risk
- Blood pressure results
- Cholesterol results
- Referral to program

# Category III

- Section guidelines revised to clarify retention/archiving of Category III codes
- 31 new, 3 revised, 9 deleted

# Modifiers

- Modifier 33, mandated preventive services, added last year, still not listed inside front cover of CPT
- Modifier 92, alternative lab platform testing, added last year, still not listed inside front cover of CPT