What's New in CPT® for 2010?

By Cristina Bentin, CCS-P, CPC-H, CMA

Cristina Bentin, CCS-P, CPC-H, CMA, is the founder and principal of ASC Association supporter member Coding Compliance Management.

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Changes the American Medical Association (AMA) introduced in its Current Procedural Terminology (CPT®) codes for 2010 reemphasize the need for staff education and correct coding practices at your ASC, where less than perfect documentation and coding could significantly impact your bottom line. This article provides an overview of the changes ASC coders can expect to encounter in 2010.

In 2010, the Surgery section of the CPT manual has 79 new CPT codes and 95 revised codes. Almost half of the new codes are located in the Musculoskeletal System section (see the chart at the top of page 41). In addition, 23 codes previously included in the Surgery section are no longer available.

Resequencing Initiative Implemented in 2010

In 2010, the most notable change the AMA introduced in its CPT manual is a resequencing initiative, or an out-of-sequence system that impacts 27 codes in the Surgery section of the manual, predominantly in the Musculoskeletal System section. According to the AMA, the resequencing system was introduced to extend the existence of the current CPT numbering system and provide flexibility of CPT content.

In the past, as CPT changes occurred, certain code series were deleted and renumbered. Resequencing allows existing codes to be relocated to a new section of the manual to better accommodate the code concept, regardless of the numeric sequence in which the code falls.

Code numbers that fall within a family of anatomically related procedures or a subsection have been assigned whenever possible. If no code numbers within a respective section or series of codes are available, the closest code number within that section has been assigned and placed in the appropriate location. Resequenced codes are located in the sections where the user would normally find those procedures listed.

2010 CPT SURGERY CHANGES

	NEW	DELETED	REVISED
Auditory	0	0	0
Cardiovascular	8	2	6
Digestive	7	5	18
Eye	0	0	0
Integumentary	2	1	1
Musculoskeletal	41	8	54
Nervous	10	5	0
Reproductive	1	0	3
Respiratory	6	0	9
Urinary	4	2	4

Resequenced codes are now flagged with the # symbol. Additionally, the CPT manual includes references at the location where the out-of-sequenced code would normally be found. These references direct users to the code series where the resequenced code can now be found.

The AMA guide *CPT® 2010 Professional Edition* provides a Summary of Resequenced CPT Codes in its Appendix N. The summary cites CPT codes that do not appear in numeric sequence within the list of CPT codes in the manual.

The box below contains an example of a series of resequenced codes as they would actually appear in the CPT manual.

ASCs that use electronic data systems should ensure CPT files exported for 2010 include the complete descriptions of the CPT codes. Files using a truncated description with numerical sorting of the codes won't capture the complete description of the codes and could lead to reporting and billing errors.

Integumentary System

Adjacent Tissue Transfers

For 2010, a revision has been made to the guidelines for adjacent tissue transfer procedures. The revised guidelines now describe the appropriate application of two new codes created to replace CPT 14300. These codes differentiate between minimal and more extensive adjacent tissue transfer procedures. In the 2010 CPT manual, this information appears as follows:

(14300 has been deleted. To report, see 14301, 14302)

Sample Resequenced Codes

▲ 27327—Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm

● 27337—3 cm or greater

▲ 27328—Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm

● 27339—5 cm or greater

27329 Code is out of numerical sequence. See 27323–27365

To order a copy of the American Medical Association's 2010 CPT codes and the companion resource *CPT® Changes 2010: An Insider's View*, go to www.ama-assn.org.

● 14301—Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm

+● 14302—each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)

ASC coders should remember that, on its own, undermining of the adjacent tissues to achieve closure does not constitute adjacent tissue transfer procedures. Pending clinical documentation codes from other series may be more specific.

Code assignment is based on square centimeters (sq cm) that are calculated by multiplying the dimensions of the covered defect. The measurement should include the flap created to close both the primary (the excision) and secondary (the wound created by the flap) defects.

Musculoskeletal System

When reviewing the 2010 changes to the CPT codes, the most substantial change can be found in the revision of soft tissue tumor

codes. CPT codes have been expanded to accommodate an additional level of service according to the size of the tumor.

Coders will be met with 41 new and 54 revised CPT codes within the Musculoskeletal System section of the 2010 CPT manual. Eight codes that were previously available are no longer included. Many of the code changes center on the revisions or additions to the soft tissue tumor excisions, and many involve resequencing. Detailed documentation is key to determining code selection for soft tumor excisions as "size" now matters in 2010.

Gone are the days when code selection for a soft tissue tumor meant knowing if the tumor was found within the subcutaneous, deep, subfascial or intramuscular area without regard to size. New code verbiage reflects size ranges for both the excision of soft tissue tumors, subcutaneous, subfascial (eg, intramuscular) and the radical resection of soft tissue tumor codes. An example of the new code verbiage appears in the box at right.

Despite the AMA's best effort to provide specific and concise coding guidelines for these new and revised CPT codes, contradictory information has surfaced. The AMA publication *CPT® Changes 2010: An Insider's View* uses the same guidelines for applying the soft tissue codes as the Integumentary System section of the CPT manual guidelines for lesion coding/reporting. During the AMA's CPT and RBRVS 2010 Annual Symposium, however, coding guidelines provided for the excision of soft tissue tumors contradict the written publications. Physicians from the American College of Surgeons and the American Academy of Orthopaedic Surgeons who made presentations at the symposium verbally stated, "The entire size of the resection determines the code."

Sample New Verbiage for Soft Tissue Tumor Excision

▲ **25075**—Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm

\# ● **25071**—3 cm or greater

▲ **25076**—Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm

\# ● **25073**—3cm or greater

Since users must have credible written documentation when making code selections/determinations, the AMA was asked to clarify the discrepancy between its written guidelines and the verbal clarification provided at the AMA symposium. During the symposium, presenters stated that an additional Errata will be issued during the year to clarify the AMA's position and correct the written publications. Until such an additional Errata is published, ASCs should not change their coding methodology from the written guidance in the CPT manual.

Respiratory System

A parenthetical note directing users to apply modifier -52, reduced services, to CPT 30140, Submucous resection inferior turbinate, partial or complete, any method, when turbinate reduction was performed has been deleted in 2010. This change, in conjunction with revisions to CPT codes 30801–30802, is sure to resolve many questions regarding turbinate coding.

The AMA revised the language in its turbinate ablation CPT codes 30801–30802 to clarify that radiofrequency ablation of the mucosa of the inferior turbinates and reduction of the turbinates are inherently included as part of the ablation procedure. Examples of these revisions follow.

30140—Submucous resection inferior turbinate, partial or complete, any method

▲ 30801—Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g., electrocautery, radiofrequency ablation, or tissue volume reduction); superficial

▲ 30802—intramural (ie, submucosal)

Cardiovascular System

CPT codes 33216–33217 now incorporate editorial revisions that reflect the number of electrodes inserted, rather than the type of device (i.e., single, dual, or multiple cardioverter-defibrillator). For example,

◉▲ 33216—Insertion of a single transvenous electrode, permanent pacemaker or cardioverter-defibrillator

◉▲ 33217—Insertion of 2 transvenous electrode; permanent pacemaker or cardioverter-defibrillator

◉▲ 33223—Revision of skin pocket for cardioverter-defibrillator

To calculate Medicare's 2010 reimbursement rates for your ASC, use the rate calculator available at www.ascassociation.org/medicare2010.

Digestive System

Anorectal Fistula

Category III code 0170T has been deleted and elevated to a Category I CPT Code as follows:

- 46707—Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])

Hemorrhoid Procedures

The hemorrhoidectomy section of the CPT manual now includes revised language that more specifically identifies the procedure(s) than in the past. In addition, that section of the manual includes its share of resequenced codes with reference notes added where the codes would normally be found in their original numerical sequence. Those notations direct the user to the appropriate code series for codes currently placed non-sequentially. Examples of the revisions appear in the box below.

The AMA also revised CPT codes 46250, 46255 and 46260, adding descriptive verbiage that identifies the most specific procedure performed. Note the following CPT verbiage change from 2009 to 2010:

46250—Hemorrhoidectomy, external, ~~complete~~

▲ 46250—Hemorrhoidectomy, external, 2 or more columns/groups

CPT directs users to report 46999, Unlisted procedure anus, for a hemorrhoidectomy, external, for single column/group. Changes include

46255—Hemorrhoidectomy, internal and external, ~~simple~~

▲ 46255—Hemorrhoidectomy, internal and external, single column/group

46260—Hemorrhoidectomy, internal and external, ~~complex or extensive~~

▲ 46260—Hemorrhoidectomy, internal and external, 2 or more columns/groups

Colorectal Surgery

Two new CPT codes (45171 and 45172) were established to capture the work involved in performing a full versus a partial-thickness excision via a transanal approach. According to the AMA, CPT 45171 was established for partial-thickness excision from the rectal wall for surgeries such as the excision of small polyps or benign tumors that are too close in proximity to the anal verge to be amenable to the less invasive endoscopic excision.

CPT 45170 was deleted for 2010. A cross-reference directs users to report "excision of rectal tumor, transanal approach, see 45171, 45172 (For transanal endoscopic microsurgical [ie, TEMS] excision of rectal tumor, use 0184T)." Information on those two CPT codes follows.

- 45171—Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)
- 45172—Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness).

Abdomen, Peritoneum, Omentum

For 2010, CPT code 49411 was established to meet the demands of evolving technology and the interstitial placement of devices (via percutaneous, intra-abdominal, intrapelvic, retroperitoneum approach), such as fiducial markers, for the purpose of radiation therapy guidance. The code is to be reported only one time, regardless of the number of devices placed.

Sample Revised Language for Hemorrhoidectomy

▲ 46221—Hemorrhoidectomy, internal, by rubber band ligation(s)

▲ 46946—2 or more hemorrhoid columns/groups

▲ 46220—Excision of single external papillae or tag, anus

▲ 46320—Excision of thrombosed hemorrhoid, external

● 49411—Placement of interstitial device(s) for radiation therapy guidance (ie, fiducial markers, dosimeter), percutaneous, intra-abdominal, intrapelvic (except prostate), and/or retroperitoneum, single or multiple

Urology System

CPT 52282 was revised to specify a permanent urethral stent insertion and distinguish it from a new code established for a temporary prostatic urethral stent insertion, CPT 53855. The code description reads as follows:

▲ 52282—Cystourethroscopy, with insertion of permanent urethral stent

Category III code 0084T was deleted and Category ICPT 53855 was added in the Other Procedures section of the Urinary System portion of the CPT manual.

A small percentage of patients who have microwave therapy may potentially require a temporary prostatic urethral stent insertion a few days after the microwave therapy procedure to manage voiding dysfunction during the healing phase (the insertion being the only treatment provided that day). The code description reads as follows:

● 53855—Insertion of a temporary prostatic urethral stent, including urethral measurements

Female Genital System

CPT 57426 was added to address the need to revise and/or remove a prosthetic vaginal graft via a laparoscopic approach. Users should note the cross-reference following CPT 57295 (Revision including removal of prosthetic vaginal graft; vaginal approach) and CPT 57296 (open abdominal approach) directing the reporting of CPT 57426 when the procedure is performed via a laparoscopic approach.

● 57426—Revision (including removal) of prosthetic vaginal graft, laparoscopic approach

Nervous System

Neurostimulators (Spinal)

Four new codes were established in 2010 to report the removal and revision of a spinal neurostimulator electrode percutaneous array(s) and plate/paddle(s) procedures. These codes differentiate between the work involved in performing revisions, replacements or removals as well as percutaneous electrode and plate/paddle electrode procedures.

According to CPT verbiage, fluoroscopy is considered inclusive to the procedure and not separately reported. Examples follow.

● 63661—Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed

● 63662—Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy when performed.

● 63663—Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed (Do not report 63663 in conjunction with 63661, 63662 for the same spinal level)

● 63664—Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed (CPT directs users not to "report 63664 in conjunction with 63661, 63662 for the same spinal level")

Pain Management—Already impacted by declining reimbursement during the four-year transition to Medicare's new ASC payment system, CPT 2010 will now establish a new code series for facet joint injections (64490–64495). Unfortunately, reimbursement for the new facet add-on codes will decrease by approximately 50%. Codes affected include the following:

● 64490—Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with imaging guidance (fluoroscopy or CT), cervical or thoracic; single level

+ ● 64491—second level

+ ● 64492—third and any additional level(s)

● 64493—Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with imaging guidance (fluoroscopy or CT), lumbar or sacral; single level.

+ ● 64494—second level

+ ● 64495—third and any additional level(s)

See the chart below for changes in the related reimbursement rates.

Changes in Pain Management Reimbursement

2009 CPT	2009 MEDICARE REIMBURSEMENT RATE	2010 CPT	2010 MEDICARE REIMBURSEMENT RATE	2009-2010 CHANGE IN MEDICARE REIMBURSEMENT
64470	307.09	64490	288.44	-18.65
+64472	236.01	+64491	102.38	-133.61
+64472	236.01	+64492	102.38	-133.61
64475	307.09	64493	288.44	-18.65
+64476	212.55	+64494	102.38	-110.17
+64476	212.55	+64495	102.38	-110.17

Other pain management concerns coders should keep in mind include the following:

- Imaging guidance (fluoroscopy, CT, ultrasound), while inclusive to the facet injection(s), must be clinically documented when utilized. CPT guidelines direct users to report tendon/trigger point injection code series 20550–20553 (MCR 2010 reimbursement range $19.32–21.02) in the absence of imaging, further decreasing the reimbursement.
- Facet injections with fluoroscopic guidance are coded toward the 64490–64495 code series.
- Facet injections with ultrasound guidance are reported with Category III Code series (0213T–0218T) per the AMA's CPT Errata for 2010. The Errata is an addendum to the CPT manual and contains errors discovered after the manual was printed as well as the corrections of these errors. ASCs should review the AMA CPT 2010 Errata for coding directives that may need to be revised within the CPT Manual. The most recent CPT 2010 Errata may be obtained from the AMA at the following web site: http://www.ama-assn.org/ama1/pub/upload/mm/362/2010-cpt-corrections.pdf
- Add-on codes +64492 and +64495 should not be reported more than once per day. Reimbursement for facet joint injection(s) is capped at no more than 3 levels despite work performed at additional levels.
- Note: Newly implemented Category III Codes are more specific for facet injections with ultrasound guidance and are also found on the Medicare List of Separately Payable Procedures. The following codes are scheduled to be implemented on January 1, 2010, but will **not** appear in the AMA CPT Book until 2011!
  - **0213T**—Facet injection(s), with ultrasound guidance, cervical or thoracic; single level
  - **0214T**—Facet injection(s), with ultrasound guidance, cervical or thoracic; second level
  - **0215T**—Facet injection(s), with ultrasound guidance, cervical or thoracic; third and any additional level(s)
  - **0216T**—Facet injection(s), with ultrasound guidance, lumbar or sacral; single level
  - **0217T**—Facet injection(s), with ultrasound guidance, lumbar or sacral; second level
  - **0218T**—Facet injection(s), with ultrasound guidance, lumbar or sacral; third and any additional level(s)

ASCs should be vigilant in verifying that correct coding and reimbursement is being captured for actual facet injections rather than trigger point injections when clinical documentation supports the facet procedure. In 2010, with the bundling of fluoroscopy into these injections, facilities should ask their Medicare administrative contractors and commercial carriers about their respective reporting guidelines to ensure accurate reimbursement is captured. Any directives provided by the carriers that are contrary to correct coding should be provided to the ASC in writing. ASC