

## 2005 CPT Code Update

There are 362 code changes (158 new codes, 83 new modifiers, 46 deleted codes and 75 revisions) to *Current Procedural Terminology (CPT®)* for 2005. Four new appendixes have also been added: Appendix F, G, H and I. The new appendixes list the codes exempt from use of modifier 63, codes exempt from separately reporting conscious sedation codes, full descriptions of the measures applicable to Category II codes, and the new genetic testing modifiers.

This summary provides a high-level overview of the additions, revisions and deletions to *CPT* for 2005 but does not address or imply coverage or reimbursement of a procedure or service, unless noted. A final decision to pay or deny a claim will not be made until a claim has been received and processed according to the member's certificate of coverage and/or the provider contract.

### Evaluation and Management

The neonatal age in the pediatric critical care codes was changed to be 28 days of age or less, which is now consistent with the ICD-9-CM diagnosis codes. In 2004, the age was from 31 days up through 24 months of age.

### Anesthesia

A code was created due to the increase in the number of surgical repairs of congenital heart lesions in children less than 1 year of age. Correction of congenital heart disease defects can now be done shortly after birth due to advances in technology and improvement in surgical techniques. This code more accurately describes the high-risk administration of anesthesia to these children.

00561 *Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, under one year of age.*

### Surgical

For 2005, new transplant codes and guidelines were created to report lung, heart/lung, intestine, liver, pancreas, and kidney transplantations. Ten new Category I CPT codes were created from previous Category III codes. Also, as in 2004, further revisions and additions were performed in the bronchoscopy section of codes.

Three new debridement codes were added that are site specific and are more extensive than the existing debridement or wound management codes. They are generally performed on high-risk patients and are performed by physicians.

11004 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum*

11005 *abdominal wall, with or without fascial closure*

11006 *external genitalia, perineum and abdominal wall, with or without fascial closure*

+11008 *Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection (List separately in addition to code for primary procedure)*

Three codes were added to describe catheter placement/removal for interstitial radioelement application following partial mastectomy:

- 19296 *Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy*
- +19297 *Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)*
- 19298 *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance*

- Reimbursement will be based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) facility/nonfacility differential reimbursement logic. Reimbursement for these new codes will be calculated using the CMS RVUs based on the site of service (office/facility). If performed in an office setting, reimbursement includes physician work, malpractice and overhead cost components. If performed in a facility setting, reimbursement represents the professional services only.

Per Medica's coverage policy "Autologous Chondrocyte Transplantation (ACT)," the following new code will deny as **investigative**:

27412 *Autologous chondrocyte implantation, knee*

Per Medica's coverage policy "Mosaicplasty for Femoral Condyle Defects," the following new code will be **covered**:

29866 *Arthroscopy, knee, surgical; osteochondral autograft(s), (eg, mosaicplasty) (includes harvesting of the autograft)*

New codes were established to report endovenous ablation for incompetent veins:

- 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated.*
- +36476 *second and subsequent veins treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)*
- 36478 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated.*
- +36479 *second and subsequent veins treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure).*

- *Prior authorization is required.* For specific criteria, please refer to the Medica UM Policy "Endovenous Radiofrequency or Laser Ablation for Varicose Veins and Chronic Venous Insufficiency" and the December 2004 *Medica Connections*, pages 9-10. (Note that codes 36478 and 36479 were incorrectly stated in that edition.)
- CPT 36476 and 36479 are not eligible for reimbursement per the policy and will deny as provider liability.
- Reimbursement will be based on the CMS National Physician Fee Schedule (NPFS) facility/nonfacility differential reimbursement logic. Reimbursement for these new codes will be calculated using the CMS RVUs based on the site of service (office/facility). If performed in an office setting, reimbursement includes physician work, malpractice and overhead cost components, including the cost of the catheter. If performed in a facility setting, reimbursement represents the professional services only.
- If performed in an office setting, submission of the unlisted code A4649, *Surgical supply, miscellaneous*, for the catheter will no longer be required.
- Codes 36475 and 36478 include imaging guidance services

Per Medica's coverage policy "Endoscopic Procedures for Treatment of GERD," the following new code will deny as **investigative**:

- 43257 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux*
- This is for the Stretta® system.
  - In 2004, this was reported with Category III code 0057T.

New codes for laparoscopic gastric restrictive procedures were created. For additional information, refer to Medica's coverage policy "Gastrointestinal Surgery for Morbid Obesity":

- 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150cm or less)*
- 43645 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption*

Code 58565 was established for reporting fallopian tube cannulation and placement of permanent implants for elective female sterilization.

- 58565 *Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants*
- Also known as Essure® procedure – a non-covered service in 2004 when submitted with code S2255
  - Effective January 1, 2005, 58565 will be a **covered** service. Refer to Medica's coverage policy "Essure® Micro-Insert System." For Medicare members, refer to Medicare's sterilization criteria.
  - See December 2004 *Medica Connections*, page 9.
  - Reimbursement will be based on the CMS NPFS facility/nonfacility differential reimbursement logic. Reimbursement for these new codes will be calculated using the CMS RVUs based on the site of service (office/facility). If performed in an office setting, reimbursement includes physician work, malpractice and overhead cost components, including the cost of the implants. If performed in a facility setting, reimbursement represents the professional services only.

## Radiology

Changes for 2005 include 13 new codes, 11 deleted codes and 18 code changes in the radiology section. There were also significant additions to the guidelines that provide clarity related to appropriate coding in the Vascular Procedures and Diagnostic Ultrasounds subsections.

- 78810 *Tumor imaging, positron emission tomography (PET) metabolic evaluation*
- Deleted and replaced with 6 new PET and PET/CT imaging codes (78811-78816).
  - The CPT codes for PET scan services should not be submitted for Medicare members; see HCPCS G0210-G0234, G0252-G0254, G0296 and G0330-G0336.

## Pathology and Laboratory

Nineteen new codes were added in this section, 1 was deleted and 10 codes were changed. Changes were also made to the guidelines related to existing genetic testing codes 88230-88299 with reference to Appendix I – Genetic Testing Code Modifiers.

- 88180 *Flow cytometry; each cell surface, cytoplasmic or nuclear marker*
- Deleted in 2004.
  - Was reported in units.

For 2005, two new codes were developed to report the technical component of flow cytometry and three codes were developed to report the interpretation services:

- 88184 *Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker;*
- +88185 *each additional marker (List separately in addition to code for first marker)*
- 88187 *Flow cytometry, interpretation; 2 to 8 markers*
- 88188 *9 to 15 markers*
- 88189 *16 or more markers*

## Medicine

There are four new immunization administration codes for patients under 8 years of age when the physician provides face-to-face counseling to the patient/family prior to the administration of a vaccine. Codes are limited to physician, nurse practitioner (NP) or physician assistant (PA) reporting only.

90465 *Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day*

+90466 *each additional injection (single or combination vaccine/toxoid), per day*

90467 *Immunization administration under age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day*

+90468 *each additional administration (single or combination vaccine/toxoid), per day*

**Note:** Immunization administration codes 90471-90474 should not be submitted in addition to administration codes 90465-90468.

New codes were created for esophageal acid reflux tests. These codes describe the trans-nasal placement of a pH electrode that ideally will record esophageal pH for a 24-hour period or less:

91034 *Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation*

91035 *with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation*

91037 *Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;*

91038 *prolonged (greater than 1 hour, up to 24 hours)*

### New subsection for Acupuncture with 4 new codes

Codes 97780 and 97781 were deleted and four new codes were developed for reporting acupuncture services. The codes are separated into acupuncture services with and without electrical stimulation.

97810 *Acupuncture, one or more needles, without electrical stimulation; initial 15 minutes of personal one-on-one contact with the patient*

+97811 *each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)*

97813 *Acupuncture, one or more needles, with electrical stimulation; initial 15 minutes of personal one-on-one contact with the patient*

+97814 *each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)*

The reporting of these services will now be based on 15-minute intervals of personal (face-to-face) contact with the patient and not the duration of acupuncture needle placement.

Note: Acupuncture is a non-covered service for Medicare members.

## Category II Codes

- Includes four new codes (0500F-0503F) for maternity care management.
- Intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care.
- Describe clinical components that may be typically included in E&M services and other clinical services and, therefore, do not have a relative value associated with them.
- Supplemental tracking codes – Informational only.

## Category III Codes

- Temporary codes for emerging technology, services and procedures; allows for data collection for these services and procedures.
- Inclusion of a service or procedure in this section neither implies nor endorses clinical efficacy, safety or the applicability to clinical practice.
- Utilization is monitored for five years and codes in this section may or may not become a Category I CPT code or may be deleted.

In addition to the Category III code, Medica requests the submission of an appropriate unlisted CPT code for the service with documentation. The unlisted code will be processed and the Category III code will be disallowed with reason code 479 (“Resubmit under other code for processing”) but recorded for tracking purposes.

## Appendix G - Summary of CPT codes which include Conscious Sedation (CPT 99141, 99142)

In 2005, *CPT* has identified codes that include conscious sedation as an inherent part of the procedure. The codes are identified with a *~* symbol. Per *CPT*, “Conscious sedation is defined as moderate sedation/analgesia and is a drug-induced depression of consciousness during which patients respond knowingly and intentionally to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is usually maintained.”

These services, identified with a *~* symbol, include conscious sedation; it is not appropriate for the same physician to report both the service and one of the conscious sedation codes. It is expected that if conscious sedation is provided to the patient as part of one of these services, it is provided by the same physician who is providing the service.

There are no RVUs assigned to codes 99141 and 99142 and no reimbursement is made unless otherwise specified in contractual agreements.

## Appendix I – Genetic Testing Code Modifiers

- Includes 83 new modifiers for reporting with molecular laboratory procedures related to genetic testing.
- Numeric/Alpha – reported with laboratory testing procedures 88230-88299 for oncologic or inherited diseases
- Introductory guidelines in the molecular diagnostic and molecular cytogenetic code sections of *CPT* provide further guidance in application of the modifiers.

Example:	Modifier	Definition
	0A	BRCA1 (Hereditary Breast/Ovarian Cancer)

## Grace Period

The grace period for the new CPT/HCPCS codes has been eliminated. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) transaction and code set rule requires the use of national medical code sets that are valid at the time that the service is provided. Providers must submit the new CPT and HCPCS codes beginning with January 1, 2005, dates of service. Claims submitted with expired codes will be denied.

## CPT Errata

The *CPT* 2005 Errata is available on the following Web site:  
<http://www.ama-assn.org/ama/pub/category/3896.html>

## Reference Materials

Providers are encouraged to use the 2005 coding reference books for more detail on the changes. The following information is provided for your convenience:

### **CPT-4**

Current Procedural Terminology, Fourth Edition (CPT-4) codes are updated and published annually by the American Medical Association (AMA). This book may be purchased directly from the AMA (1-800-621-8335) or through a number of other book vendors (e.g., St. Anthony Publishing/Medicode).

### **CPT Assistant**

This newsletter is the official coding resource for CPT. For information on ordering, call the AMA at 1-800-621-8335.

### **ICD-9-CM**

International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification (ICD-9-CM) books are updated and published annually. They may be purchased directly from the AMA (1-800-621-8335) or through a number of other book vendors (e.g., St. Anthony Publishing/Medicode).

### **Coding Clinic**

This bulletin is the official coding resource for ICD-9-CM and may be purchased directly from the American Hospital Association by calling 1-800-242-2626.

### **HCPCS Manual**

The HCPCS Level II book is updated and published annually. It can be purchased directly from the AMA or through a number of other book vendors (e.g., St. Anthony Publishing/Medicode).

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