2012 CPT Coding Updates

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Objective

- Overview of the New, Revised and Deleted CPT codes for 2012

Evaluation and Management

- Decision Tree for New vs. Established Patient is included in the 2012 manual
- Definition for New and Established Patients was Revised.
New Patient

A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Established Patient

An established patient is one who has received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
Evaluation and Management

Initial Observation Care Codes (99218-99220) where revised to include typical time.

<table>
<thead>
<tr>
<th>CPT</th>
<th>Typical Time</th>
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<tbody>
<tr>
<td>99218</td>
<td>30 minutes</td>
</tr>
<tr>
<td>99219</td>
<td>50 minutes</td>
</tr>
<tr>
<td>99220</td>
<td>70 minutes</td>
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Evaluation and Management

Prolonged Services
- Revisions include the removal of “physician” and “face to face” in the code descriptions for 99354-99359
- Addition of “observation” as a site of service for codes 99356-99357
- Codes 99358-99359 are reported for prolonged services without direct patient contact
Integumentary System

- 11975 and 11977 Deleted
- The codes were used to report the insertion and removal with reinsertion of implantable contraceptive capsules

Integumentary System

- Revision to Coding Guidelines for Repairs
  - Multiple repairs of different classifications report with modifier 59
  - Example: An intermediate repair of the arm measuring 3.0 cm and a complex repair of the abdomen measuring 4.5 cm
    - Codes: 13101, 12031-59
Integumentary System

- Skin Replacement Surgery
  - Coding Guidelines updated
  - Revised: Six Codes
  - Deleted: 24 Codes
  - New: Eight Codes

Integumentary System

New Skin Substitute Codes
- 15271 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
- +15272 each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
Integumentary System

New Skin Substitute Codes

● 15273 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

● +15274 each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

Integumentary System

New Skin Substitute Codes

● 15275 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

● +15276 each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
Integumentary System

New Skin Substitute Codes

- 15277 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, 1% of body area of infants and children, or part thereof
- +15278 each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children or part thereof (List separately in addition to code for primary procedure)

Example: A 345 sq cm skin substitute graft of the right arm and a 95 sq cm skin substitute graft of the left arm

Codes: 15273, 15274 x 4
Integumentary System

- +15777 Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)

Musculoskeletal System

- 20527 Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren’s contracture)

- 26341 Manipulation, palmar fascial cord (ie, Dupuytren’s cord), post enzyme injection (eg, collagenase), single cord
Musculoskeletal System

Revision to Percutaneous Vertebroplasty codes (22520-22522) to include a bone biopsy when performed

Example: Vertebroplasty performed on L2 and a bone biopsy performed on T12.
Codes 22521, 20225-59

Musculoskeletal System

Arthrodesis

- Revised: 2 codes (22610, 22612)
- New: 2 codes
  - 22633 Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar
  - +22634 each additional interspace and segment
Musculoskeletal System

27096 was revised to include CT or fluoroscopic imaging guidance and arthrography when performed

Musculoskeletal System

Application of multi-layer compression system
- 29581 Application of multi-layer compression system; leg (below knee), including ankle and foot
- 29582 thigh and leg, including ankle and foot, when performed
- 29583 upper arm and forearm
- 29584 upper arm, forearm, hand, and fingers
Musculoskeletal System

- +29826 Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)

Musculoskeletal System

Description of meniscectomy codes 29880 and 29881 were revised to include chondroplasty when performed on the same or separate compartment(s)

Example: Chondroplasty is performed on the medial compartment of the right knee and a meniscectomy is performed on the lateral compartment of the right knee
Code: 29881-RT
Respiratory System

- Revisions to coding guidelines in the Lungs and Pleura subsection
- Deleted: Eight codes
- Revised: 22 codes
- New: 18 codes

Respiratory System

Code 32095 was deleted and replaced with three new codes.

- 32096 Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
- 32097 Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
- 32098 Thoracotomy, with biopsy(ies) of pleura
Respiratory System

- Revision to Thoracotomy codes 32100-32160
- 32404 was deleted. Use new code 32098 to report the service
- 32405 revised to include moderate sedation
- Revision to Removal of Lung codes 32440-32491

32500 was deleted and three new codes were added:
- 32505 Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial
- +32506 Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)
- +32507 Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)
Respiratory System

Thoracoscopy Video-Assisted Thoracic Surgery (VATS)
- 32602, 36203, 32605 have been deleted. Report with revised code 32601
- 32660 was deleted
- 32607 Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
- 32608 Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
- 32609 Thoracoscopy; with biopsy(ies) of pleura

Respiratory System

32657 was deleted. Three new codes were created:
- 32666 Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral
- +32667 Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)
- +32668 Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)
Respiratory System

- New codes 32669-32674

Cardiovascular System

- Pacemaker changes
  - Changes to guidelines
    - Radiologic S&I included with codes 33206-33249 (71090 was deleted)
    - 76000 can be reported for diagnostic lead evaluation without a lead procedure
  - Revised: 14 codes
  - New: 9 codes (all resequenced)
Cardiovascular System

➢ Pacemaker changes continued
  • New or replacement permanent pacemaker with leads reported with 33206-33208
  • Insertion of pacemaker pulse generator only reported with 33212-33213, 33221
  • Removal and replacement of permanent pacemaker pulse generator reported with 33227-33229
  • Insertion of pacemaker leads reported with 33216, 33217 or 33217 and 33224

Cardiovascular System

➢ Pacemaker changes continued
  • Insertion or replacement of a pacing cardioverter-defibrillator pulse generator and leads reported with 33249. 33225 would be reported with 33249 for a multiple lead system
  • Insertion of pacing cardioverter-defibrillator pulse generator only reported with 33240, 33230-33231
  • Removal with replacement of the cardioverter-defibrillator pulse generator reported with 33262-33264
Cardiovascular System

Cardiac Assist

- Revised description for 33960 and 33961 was changed from 24 hours to initial day and subsequent day.

Cardiovascular System

Bypass Grafts

- Deletion of codes 35548, 35549
  - Aortoiliacofemoral

- Deletion of codes 35551, 35651
  - Aortofemoral
Cardiovascular System

Moderate sedation symbols have been added to 36200, 36245-36248

Cardiovascular System

New codes added for renal catheterization and angiography

- 36251 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

- 36252 bilateral
Cardiovascular System

• 36253 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral
• 36254 bilateral

Cardiovascular System

Intravascular Vena Cava Filter

• 37191 Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed
• 37192 Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed
Cardiovascular System

Intravascular Vena Cava Filter

- 37193 Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

Cardiovascular System

Ligation

Deletion of code 37620

- 37619 Ligation of inferior vena cava
Cardiovascular System

Bone Marrow Harvesting

• 38232 Bone marrow harvesting for transplantation; autologous

Digestive System

47000 revised to include moderate sedation

49080 and 49081 were deleted and replaced with three new codes:
- 49082 Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance
- 49083 Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance
- 49084 Peritoneal lavage, including imaging guidance, when performed
Nervous System

• Coding guidelines updated for Injection, Drainage or Aspiration
  – Fluoroscopy can be reported separately when used for placement of injections with 62310-62319
  – Proper use of 62310-62311 and 62318-62319
  – Indirect visualization

Nervous System

Reservoir/Pump Implantation
  – Revision was made to 62367
  – Two new codes:
    • 62369 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill
    • 62370 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician’s skill)
Nervous System

Laminotomy
- Revision for open procedures 63020-63035
- Percutaneous endoscopic approach reported with 0274T-0275T

Nervous System

Neurostimulators
Revisions to codes 64553, 64555, 64561, 64565, 64575, 64580, 64581, 64585 to include “array”
Deletion of 64560 and 64577
Nervous System

Destruction by Neurolytic Agent

- Revision to Coding Guidelines
- Codes 64622-64627 deleted and replaced with four new codes:
  - # 64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); cervical or thoracic, single facet joint
  - # +64634 each additional facet joint (List separately in addition to code for primary procedure)
  - # 64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); lumbar or sacral, single facet joint
  - # +64636 each additional facet joint (List separately in addition to code for primary procedure)

Auditory System

Code 69802 was deleted
Radiology

Head and Neck
Code 70355 was revised to include (eg panoramic X-ray)

Radiology

Chest
- Deletion of 71090. Report with 33206-33249
Radiology

Spine and Pelvis
Revision of Lumbosacral Spine X-rays
▲ 72114 Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views
▲ 72120 Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views

Radiology

Lower Extremities
➢ Deletion of 73542. Radiology service included with 27096
Radiology

Abdomen
• 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing*

Radiology

Angiography
➢ Deletion of 75722 and 75724. Report with 36251, 36253 and 36252, 36254
Radiology

Transcatheter Procedures

- Deletion of 75940. Report with 37191

Radiology

Transcatheter Procedures

- Revisions to 75962, 75964
Radiology

Fluoroscopic guidance
Revision to 77003

Radiology

Bone/Joint Studies

- Deletion of 77079 and 77083
Radiology

Radiation Treatment Management and Delivery

Three new codes added:

- # 77424 Intraoperative radiation treatment delivery, x-ray, single treatment session
- # 77425 Intraoperative radiation treatment delivery, electrons, single treatment session
- # 77469 Intraoperative radiation treatment management

Radiology

Gastrointestinal System

- Deleted 78220 and 78223
- Two new codes
  - 78226 Hepatobiliary system imaging, including gallbladder when present;
  - 78227 with pharmacologic intervention, including quantitative measurement(s) when performed
Radiology

Nuclear Medicine-Respiratory System

- Revised: One code
- Deleted: Nine codes
- New: Four codes
  - 78579 Pulmonary ventilation imaging (eg, aerosol or gas)
  - 78582 Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging
  - 78597 Quantitative differential pulmonary perfusion, including imaging when performed
  - 78598 Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed

Laboratory and Pathology

Molecular Pathology

- New Section
- Review all guidelines and definitions
- Tier 1 Molecular Pathology Procedures
- Tier 2 Molecular Pathology Procedures
- Total of 101 new codes
Vaccination administration
- Revised codes 90460 and 90461
- Example: Admin codes for DTaP and MMR
  90460 x 2, 90461 x 4
- Deletion of 90470 and 90663

Therapeutic repetitive transcranial magnetic stimulation (TMS)
- 90867 Reported for the initial service
- 90868 Reported for the subsequent services
- 90869 Added to report subsequent motor threshold determination
Medicine

Special Ophthalmological Services

- Deletion of 92070. Replaced with two new codes:
  - 92071 Fitting of contact lens for treatment of ocular surface disease
  - 92072 Fitting of contact lens for management of keratoconus, initial fitting

- Codes 92120 and 92130 were deleted
Medicine

Audiology Function Tests

● # 92558 Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis

Revised 92587 and 92588

Medicine

Evaluative and Therapeutic Services

➢ Revision to code 92605 and new code 92618 report the time of the service and that the service must be face to face with the patient
Medicine

Pulmonary Diagnostic Testing and Therapies (94010-94799)

- Revisions to guidelines
- Codes were deleted and created in this section to properly pulmonary testing and therapy

Medicine

- Codes 95970-+95975 have undergone minor descriptor revisions to clarify their use.
- Codes 95990-95991 have been revised to include electronic analysis of the pump when performed.
Medicine

• 96367 revised to include it is a sequential infusion of a new drug/substance

Category II Codes

Category II codes are supplemental tracking codes that can be used for performance measurement under Medicare’s Physician Quality Reporting System (PQRS) or private payer pay-for-performance programs. Use of Category II codes is optional; they are not tied to a fee schedule and are intended for data collection regarding quality of care.
Category II Codes

For 2012, CPT® has added 59 new Category II codes, revised five codes, and deleted one code. For additional information on these codes, consult your CPT® manual or the AMA website at: http://www.ama-assn.org/go/cpt. You will find a dedicated link for Category II codes to the right of the screen, under the “Related Links” menu.

Category III Codes

Category III codes describe emerging technologies and, unlike Category I “unlisted procedure” codes, allow for tracking and collection of specific data. If a Category III code is available, it must be reported instead of a Category I unlisted procedure code. Category III codes have a five-year life span: Per CPT® guidelines, if a Category III code is not replaced by a Category I code (or otherwise revised) within five years, the Category III code will be archived “unless it is demonstrated that a temporary code is still needed.”
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Introduction

As technology and clinical knowledge evolve, so does medicine. Health care also operates within a complex and ever-changing regulatory environment. To keep pace, the code sets we use to report medical services, procedures, devices, and drugs must be updated regularly.

Each November, the American Medical Association releases a revised CPT® code set for implementation the following January 1. At AAPC, our goal is to provide you with vital information to make the implementation process easier. This workbook summarizes significant CPT® 2012 code changes available at press time. Additional changes released subsequently, as addenda or errata, will be posted on AAPC’s website (www.aapc.com).

CPT® 2012 contains revised section guidelines, parenthetical references, and appendices. This guide primarily summarizes changes, deletions, and revisions to the codes and code descriptors, with a brief rationale describing these changes. Minor changes in grammar or spelling that do not affect code use may be omitted. This guide does not review in full all instructional or text revisions within CPT®, and is not meant as a replacement for the complete 2012 CPT® coding manual. Always use the most current version of CPT®, and carefully follow all CPT® section guidelines, parenthetical references, and other instruction when assigning codes.

Checklist for Updating Your Codes

- Begin reviewing 2012 CPT® code changes, using this guide
- Order 2012 code books
- Review all changes to guidelines, notes, and instructions in your book
- Highlight changes in the book’s index pertinent to your specialty, and review those changes
- Highlight changes in the book’s tabular (numeric) section pertinent to your specialty, and review those changes
- Create a documentation “cheat sheet” of 2012 updates that must be documented differently for coders to capture the information needed and distribute it to clinicians
- Review and update superbills, chargemasters, etc.
- Upload software change
- Train coding and billing staff on changes
- Check regularly for addenda or errata to the 2012 code set; if addenda are issued, communicate the contents to coding and clinical staff
- Review physician quality reporting system (PQRS) changes, if you are participating in PQRS, and educate providers/make adjustments in processes to accommodate the new reporting measures
- Communicate with payer/provider reps regarding reimbursement and coverage issues
- Archive last year’s books within three months of the new code implementation dates

Significant Changes to CPT® for 2012

Section Guidelines

CPT® 2012 includes minor changes to the evaluation and management (E/M) guidelines to clarify the meaning of “new” vs. “established” patients. New language stresses, “Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT® code(s). A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”

CPT 2012® also re-establishes the “New vs. Established Patient” Decision Tree that was included in CPT® 2010, but was left out in 2011.

There are no changes to the Anesthesia, Surgery, or Medicine section guidelines to CPT® 2012.

Modifiers

CPT® Appendix A adds two modifiers: 33 and 92.

Modifier 33 Preventive services has been effective since Jan. 1, 2011 but appears in CPT® for the first time. The modifier should be appended when reporting preventive services delivered “in accordance with a US Preventive Services Task Force A or B rating in effect” and “other preventive services identified in [legislative or regulatory] preventive services mandates.” Examples include the Medicare Initial Preventive
Physical Exam (G0402) and Annual Wellness Visits (G0438 and G0439).

You should not apply modifier 33 for separately reported services specifically identified as preventive (such as screening mammography, 77057; screening colonoscopy, G0105 or G0121; or prostate screening with PSA, G0103). If the physician converts a screening colonoscopy to a diagnostic colonoscopy (eg, 45385), you should append modifier PT Colorectal screening test converted to diagnostic test or other procedure—rather than modifier 33—to the diagnostic colonoscopy code to indicate that the procedure began as a preventive service.

Modifier 92 Alternative laboratory platform testing should be appended when:

- A laboratory test is performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable, analytical chamber;
- the test does not require permanent dedicated space; and,
- the test is designed to be carried or transported to the vicinity of the patient for immediate testing at that site.

For Medicare payers, modifier 92 indicates point-of-service HIV testing (86701–86703 and 87389) only. Per CMS transmittal 2277 (www.cms.gov/transmittals/downloads/R2277CP.pdf), the modifier is effective Oct. 1, 2011 for this purpose. Modifier 92 was introduced in CPT® 2008, and Medicare will allow you to apply the modifier retroactively to claims filed on or since Jan. 1, 2008.

Genetic testing code modifiers are covered separately in CPT® Appendix I.

**Evaluation and Management Services**

**Initial Observation Care**

▲ 99218 Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission to “observation status” are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient’s hospital floor or unit.

**AAPC Rationale**

“Reference times” have been added to initial observation care codes 99218, 99219, and 99220, based on a crosswalk from the Hospital Inpatient Services Codes. The new language allows physicians to report the initial observation care codes using time as the key component, when counseling or coordination of care dominates the encounter.

**Initial Observation Care**

▲ 99219 Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission to “observation status” are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient’s hospital floor or unit.

**AAPC Rationale**

“Reference times” have been added to initial observation care codes 99218, 99219, and 99220, based on a crosswalk from the Hospital Inpatient Services Codes. The new language allows physicians to report the initial observation care codes using time as the key component, when counseling or coordination of care dominates the encounter.

**Initial Observation Care**

▲ 99220 Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the problem(s) requiring admission to “observation status” are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient’s hospital floor or unit.

**AAPC Rationale**

“Reference times” have been added to initial observation care codes 99218, 99219, and 99220, based on a crosswalk from the Hospital Inpatient Services Codes. The new language allows physicians to report the initial observation care codes using time as the key component, when counseling or coordination of care dominates the encounter.
Prolonged Service With Direct Patient Contact

▲ +99354 Prolonged physician service in the office or other outpatient setting requiring direct patient (face-to-face) contact beyond the usual service; first hour (List separately in addition to code for prolonged service)

AAPC Rationale
With the addition of new guidelines better defining the meaning of “direct patient contact,” the term “face-to-face” has been deleted from Prolonged Services codes 99354–99359. Codes 99354–99357 also delete the term “physician” to allow reporting by other qualified health care professionals.

Prolonged Service With Direct Patient Contact

▲ +99355 Prolonged physician service in the office or other outpatient setting requiring direct patient (face-to-face) contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)

AAPC Rationale
With the addition of new guidelines better defining the meaning of “direct patient contact,” the term “face-to-face” has been deleted from Prolonged Services codes 99354–99359. Codes 99354–99357 also delete the term “physician” to allow reporting by other qualified health care professionals.

Prolonged Service With Direct Patient Contact

▲ +99356 Prolonged physician service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient evaluation and management service)

AAPC Rationale
With the addition of new guidelines better defining the meaning of “direct patient contact,” the term “face-to-face” has been deleted from Prolonged Services codes 99354–99359. Codes 99354–99357 also delete the term “physician” to allow reporting by other qualified health care professionals. Codes 99356 and 99357 may also now be used in the observation setting.

Prolonged Service Without Direct Patient Contact

▲ +99358 Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; first hour

AAPC Rationale
With the addition of new guidelines better defining the meaning of “direct patient contact,” the term “face-to-face” has been deleted from Prolonged Services codes 99354–99359. Guideline revisions also allow use of 99358–99359 by qualified health care professionals other than physicians.

Prolonged Service Without Direct Patient Contact

▲ +99359 Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; each additional 30 minutes (List separately in addition to code for prolonged service)

AAPC Rationale
With the addition of new guidelines better defining the meaning of “direct patient contact,” the term “face-to-face” has been deleted from Prolonged Services codes 99354–99359. Guideline revisions also allow use of 99358–99359 by qualified health care professionals other than physicians.

Surgery

Integumentary System/Introduction

11975 Insertion, implantable contraceptive capsules

AAPC Rationale
Code 11975 has been deleted; to report insertion of non-biodegradable drug delivery implant for contraception, use 11981 Insertion, non-biodegradable drug delivery implant.
**Integumentary System/Introduction**

11977 Removal with reinsertion, implantable contraceptive capsules

**AAPC Rationale**

Code 11977 has been deleted; to report removal of implantable contraceptive capsules with subsequent insertion of non-biodegradable drug delivery implant, use 11976 Removal, implantable contraceptive capsules and 11981 Insertion, non-biodegradable drug delivery implant.

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**Integumentary System/Skin Replacement Surgery and Skin Substitutes**

▲ 15150 Tissue cultured epidermal skin autograft, trunk, arms, legs; first 25 sq cm or less

**AAPC Rationale**

Descriptor language for codes 15150–15157 has been revised (deleting “epidermal” and replacing it with “skin”) for consistency.

+ 15151 Tissue cultured epidermal skin autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)

**AAPC Rationale**

Descriptor language for codes 15150–15157 has been revised (deleting “epidermal” and replacing it with “skin”) for consistency.

▲ 15155 Tissue cultured epidermal skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less

**AAPC Rationale**

Descriptor language for codes 15150–15157 has been revised (deleting “epidermal” and replacing it with “skin”) for consistency.

▲ 15156 Tissue cultured epidermal skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)

**AAPC Rationale**

Descriptor language for codes 15150–15157 has been revised (deleting “epidermal” and replacing it with “skin”) for consistency.

▲ 15157 Tissue cultured epidermal skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

**AAPC Rationale**

Descriptor language for codes 15150–15157 has been revised (deleting “epidermal” and replacing it with “skin”) for consistency.

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**Integumentary System/Skin Replacement Surgery and Skin Substitutes**

▲ +15170 Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children, or part thereof

**AAPC Rationale**

Codes 15170–15176 have been deleted; see new codes 15271–15278.
Integumentary System/Skin Replacement Surgery and Skin Substitutes

15171 Acellular dermal replacement, trunk, arms, legs, each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15170–15176 have been deleted; see new codes 15271–15278.

Integumentary System/Skin Replacement Surgery and Skin Substitutes

15175 Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, first 100 sq cm or less, or 1% of body area of infants and children

AAPC Rationale
Codes 15170–15176 have been deleted; see new codes 15271–15278.

Integumentary System/Skin Replacement Surgery and Skin Substitutes

15176 Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15170–15176 have been deleted; see new codes 15271–15278.

Integumentary System/Skin Replacement Surgery and Skin Substitutes

+ 15271 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

AAPC Rationale
Code 15271 is one of eight new codes to describe skin graft application, to replace deleted codes 15170–15176 and 15300–15431. The new code set describes such grafts by location and area, rather than by product description (eg, “acellular dermal replacement”).

Codes 15271 (first 25 sq. cm.) and add-on 15272 (each additional 25 sq. cm.) apply to the areas of trunk, arms, and legs for wounds of less than 100 sq. cm. For wounds in the same areas of greater than 100 sq. cm., see 15273–15274.

Supply of the skin substitute is reported separately.

Integumentary System/Skin Replacement Surgery and Skin Substitutes

+ 15272 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15271 (first 25 sq. cm.) and add-on 15272 (each additional 25 sq. cm.) apply to the areas of trunk, arms, and legs for wounds of less than 100 sq. cm. For wounds in the same areas of greater than 100 sq. cm., see 15273–15274.

Supply of the skin substitute is reported separately.

Integumentary System/Skin Replacement Surgery and Skin Substitutes

+ 15273 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

AAPC Rationale
Code 15273 is one of eight new codes to describe skin graft application, to replace deleted codes 15170–15176 and 15300–15431. The new code set describes such grafts by location and area, rather than by product description (eg, “acellular dermal replacement”).

Codes 15273 (first 100 sq. cm.) and add-on 15274 (each additional 100 sq. cm.) apply to the areas of trunk, arms, and legs for wounds equal to or greater than 100 sq cm. For wounds in the same areas of less than 100 sq. cm., see 15271–15272.

Supply of the skin substitute is reported separately.
**Integumentary System/Skin Replacement Surgery and Skin Substitutes**

- +15274 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

**AAPC Rationale**

Code 15274 is one of eight new codes to describe skin graft application, to replace deleted codes 15170–15176 and 15300–15431. The new code set describes such grafts by location and area, rather than by product description (e.g., "acellular dermal replacement").

Codes 15273 (first 100 sq. cm.) and add-on 15274 (each additional 100 sq. cm.) apply to the areas of trunk, arms, and legs for wounds equal to or greater than 100 sq. cm. For wounds in the same areas of less than 100 sq. cm., see 15271–15272.

Supply of the skin substitute is reported separately.

**Integumentary System/Skin Replacement Surgery and Skin Substitutes**

- +15276 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

**AAPC Rationale**

Code 15276 is one of eight new codes to describe skin graft application, to replace deleted codes 15170–15176 and 15300–15431. The new code set describes such grafts by location and area, rather than by product description (e.g., "acellular dermal replacement").

Codes 15275 (first 25 sq. cm.) and add-on 15276 (each additional 25 sq. cm.) apply to the areas of face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits for wounds less than 100 sq. cm. For wounds in the same areas equal to or greater than 100 sq. cm., see 15277–15278.

Supply of the skin substitute is reported separately.

**Integumentary System/Skin Replacement Surgery and Skin Substitutes**

- +15277 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, 1% of body area of infants and children, or part thereof

**AAPC Rationale**

Code 15277 is one of eight new codes to describe skin graft application, to replace deleted codes 15170–15176 and 15300–15431. The new code set describes such grafts by location and area, rather than by product description (e.g., "acellular dermal replacement").

Codes 15277 (first 100 sq. cm.) and add-on 15278 (each additional 100 sq. cm.) apply to the areas of face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits for wounds equal to or greater than 100 sq. cm. For wounds in the same areas of less than 100 sq. cm., see 15277–15278.

Supply of the skin substitute is reported separately.
Integumentary System/Skin Replacement Surgery and Skin Substitutes

+15278 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof

AAPC Rationale
Code 15278 is one of eight new codes to describe skin graft application, to replace deleted codes 15170–15176 and 15300–15341. The new code set describes such grafts by location and area, rather than by product description (eg, “acellular dermal replacement”).

Codes 15277 (first 100 sq. cm.) and add-on 15278 (each additional 100 sq. cm.) apply to the areas of face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits for wounds equal to or greater than 100 sq. cm. For wounds in the same areas of less than 100 sq. cm., see 15275–15276.

Supply of the skin substitute is reported separately.

Integumentary System/Skin Replacement Surgery and Skin Substitutes

15300 Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children

AAPC Rationale
Codes 15300–15301 have been deleted; see new codes 15271–15274.

Integumentary System/Skin Replacement Surgery and Skin Substitutes

15301 Allograft skin for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15300–15301 have been deleted; see new codes 15271–15274.

Integumentary System/Skin Replacement Surgery and Skin Substitutes

15330 Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children

AAPC Rationale
Codes 15330–15331 have been deleted; see new codes 15271–15274.

Integumentary System/Skin Replacement Surgery and Skin Substitutes

15331 Acellular dermal allograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15330–15331 have been deleted; see new codes 15271–15274.
Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15335 Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, first 100 sq cm or less, or 1% of body area of infants and children

AAPC Rationale
Codes 15335–15336 have been deleted; see new codes 15275–15278.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15336 Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15335–15336 have been deleted; see new codes 15275–15278.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15340 Tissue cultured allogeneic skin substitute; first 25 sq cm or less

AAPC Rationale
Codes 15340–15341 have been deleted; see new codes 15271–15278.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15341 Tissue cultured allogeneic skin substitute; each additional 25 sq cm, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15340–15341 have been deleted; see new codes 15271–15278.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15360 Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children

AAPC Rationale
Codes 15360–15361 have been deleted; see new codes 15271–15274.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15361 Tissue cultured allogeneic dermal substitute, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15360–15361 have been deleted; see new codes 15271–15274.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15365 Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children

AAPC Rationale
Codes 15365–15366 have been deleted; see new codes 15275–15278.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15366 Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15365–15366 have been deleted; see new codes 15275–15278.
Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15400 Xenograft, skin (dermal), for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children

AAPC Rationale
Codes 15400–15401 have been deleted; see new codes 15271–15274.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15401 Xenograft, skin (dermal), for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15400–15401 have been deleted; see new codes 15271–15274.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15420 Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children

AAPC Rationale
Codes 15420–15421 have been deleted; see new codes 15275–15278.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15421 Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15420–15421 have been deleted; see new codes 15275–15278.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15430 Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children

AAPC Rationale
Codes 15430–15431 have been deleted; see new codes 15271–15278.

Integumentary System/Skin
Replacement Surgery and Skin Substitutes
15431 Acellular xenograft implant; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 15430–15431 have been deleted; see new codes 15271–15278.

Integumentary System/Other
Flaps and Grafts
+ 15777 Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)

AAPC Rationale
Add-on 15777 is new to describe implantation of biologic implant (eg, FlexHD®) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure). Report supply of the implant separately.

Musculoskeletal/Introduction or Removal
+ 20527 Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren’s contracture)

AAPC Rationale
New code 20527 specifically describes injection of an enzyme to treat Dupuytren’s contracture, a thickening and tightening (contracture) of this fibrous tissue that can cause the fingers to curl. An injection of corticosteroid may help prevent the progression of contracture. Several injections may be needed for a lasting effect.
For manipulation of the palmar fascial cord following the injection, see new code 26341, *Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord."

**Musculoskeletal/Vertebral Body, Embolization or Injection**

▲ 22520 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic

**AAPC Rationale**
Bone biopsy, when performed, is now expressly bundled into percutaneous vertebroplasty; descriptor language for 22520–22522 is now consistent with kyphoplasty codes 22523–22525. The national Correct Coding Initiative (CCI) has bundled bone biopsy to these procedures for several years.

**Musculoskeletal/Vertebral Body, Embolization or Injection**

▲ 22521 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar

**AAPC Rationale**
Bone biopsy, when performed, is now expressly bundled into percutaneous vertebroplasty; descriptor language for 22520–22522 is now consistent with kyphoplasty codes 22523–22525. The national Correct Coding Initiative (CCI) has bundled bone biopsy to these procedures for several years.

**Musculoskeletal/Vertebral Body, Embolization or Injection**

▲ +22522 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

**AAPC Rationale**
Bone biopsy, when performed, is now expressly bundled into percutaneous vertebroplasty; descriptor language for 22520–22522 is now consistent with kyphoplasty codes 22523–22525. The national Correct Coding Initiative (CCI) has bundled bone biopsy to these procedures for several years.

**Musculoskeletal/Arthrodesis**

▲ 22610 Arthrodesis, posterior or posterolateral technique, single level; thoracic (with or without lateral transverse technique, when performed)

**AAPC Rationale**
Descriptor language for 22610 has been revised for clarity and consistency. There is no change in code application from previous years.

**Musculoskeletal/Arthrodesis**

▲ 22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique, when performed)

**AAPC Rationale**
Descriptor language for 22612 has been revised for clarity and consistency. There is no change in code application from previous years.

**Musculoskeletal/Arthrodesis**

▲ 22633 Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar

**AAPC Rationale**
New lumbar arthrodesis code 22633 (and add-on 22634) describes a combined posterior/posterolateral technique with a posterior interbody approach, including minimal laminectomy and/or discectomy to prepare the interspace. Report 22633 for the first interspace treated and 22634 for each additional interspace.

Do not report 22633 at the same level as 22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed).

**Musculoskeletal/Arthrodesis**

▲ +22634 Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace

**AAPC Rationale**
New lumbar arthrodesis code 22633 (and add-on 22634) describes a combined posterior/posterolateral technique with
a posterior interbody approach, including minimal laminectomy and/or discectomy to prepare the interspace. Report 22633 for the first interspace treated and 22634 for each additional interspace.

**Musculoskeletal System/Repair, Revision, and/or Reconstruction**

- 26341 Manipulation, palmar fascial cord (ie, Dupuytren’s cord), post enzyme injection (eg, collagenase), single cord

**AAPC Rationale**

New code 26341 describes manipulation of the palmar fascial cord, following injection of an enzyme to treat Dupuytren’s contracture as reported with 20527 Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren’s contracture). Dupuytren’s contracture is a thickening and tightening (contracture) of this fibrous tissue that can cause the fingers to curl. An injection of corticosteroid, followed by manipulation, may help to prevent progression of contracture.

**Musculoskeletal System/Introduction or removal**

- ▲ 27096 Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed

**AAPC Rationale**

Code 27096 has been revised to specifically include image guidance by fluoroscopy or computed tomography (CT) to confirm intra-articular needle positioning. Arthrography also is included, when performed. For bilateral procedures, append modifier 50 Bilateral procedure.

If sacroiliac joint injection does not include fluoroscopy or CT guidance, report 20552 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s) rather than 27096.

**Musculoskeletal System/Lower Extremity/Strapping**

- ▲ 29581 Application of multi-layer compression system; thigh and leg, including ankle and foot

**AAPC Rationale**

Descriptor language for 29581 has been revised to provide consistency with new codes 29582–29584. Compression helps to circulate blood (for instance, in diabetic patients), thus leading to improved healing.

The compression codes are reported according to the areas treated; 29581 applies to below knee systems, including ankle and foot. For above knee systems, see 29582 Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed.

Do not report 29581 with strapping procedures 29540 (ankle and/or foot) or 29580 (Unna boot); 29582; ablation procedures 36475 and 36478; or manual therapy 97140.

**Musculoskeletal System/Lower Extremity/Strapping**

- ▲ 29582 Application of multi-layer compression system; thigh and leg, including ankle and foot

**AAPC Rationale**

New and revised compression codes (29581–29584) are reported according to the areas treated; 29582 applies to thigh and leg systems, including ankle and foot. For below knee systems, see 29581 Application of multi-layer compression system; leg (below knee), including ankle and foot.

Do not report 29582 with strapping procedures 29540 (ankle and/or foot) or 29580 (Unna boot); 29581; ablation procedures 36475 and 36478; or manual therapy 97140.

Compression helps to circulate blood (for instance, in diabetic patients), thus leading to improved healing.

**Musculoskeletal System/Lower Extremity/Strapping**

- ▲ 29583 Application of multi-layer compression system; upper arm and forearm

**AAPC Rationale**

New and revised compression codes (29581–29584) are reported according to the areas treated; 29583 applies to upper arm and forearm systems. For upper arm and forearm with hand and fingers, see 29584 Application of multi-layer compression system; upper arm, forearm, hand, and fingers. Compression helps to circulate blood (for instance, in diabetic patients), thus leading to improved healing.

Do not report 29583 with 29584 or manual therapy, 97140.
Musculoskeletal System/Lower Extremity/Strapping

- 29584 Application of multi-layer compression system; upper arm, forearm, hand, and fingers

AAPC Rationale

New and revised compression codes (29581–29584) are reported according to the areas treated; 29584 applies to upper arm and forearm systems, including hand and fingers. For upper arm and forearm without hand and fingers, see 29583 Application of multi-layer compression system; upper arm and forearm. Compression helps to circulate blood (for instance, in diabetic patients), thus leading to improved healing.

Do not report 29584 with 29583 or manual therapy, 97140.

Musculoskeletal System/Endoscopy-Arthroscopy

- ▲ 29826 Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial or without-ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)

AAPC Rationale

According to the AMA, 29826 is billed more than 95 percent of the time in addition to other arthroscopic repair; for that reason, 29826 has become an add-on code for 2012. Primary arthroscopic repairs that 29826 may accompany include: 29806–29825 and 29827–29828.

Musculoskeletal System/Endoscopy-Arthroscopy

- ▲ 29880 Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving), including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed

AAPC Rationale

According to the AMA, chondroplasty is typically performed with knee arthroscopy; therefore, chondroplasty has been added as an included component of surgical arthroscopy codes 29881 medial OR lateral meniscectomy and 29880 medial AND lateral meniscectomy.

Respiratory System/Incision

- 32095 Thoracotomy, limited, for biopsy of lung or pleura

AAPC Rationale

Code 32095 has been deleted; see new codes 32096–32098.

Respiratory System/Incision

- 32096 Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral

AAPC Rationale

Code 32096 is one of three new codes created to provide more detail for the type of tissue biopsied during a thoracotomy. The procedure is reported once per lung, regardless of the number of biopsies performed. When performed on both lungs, append modifier 50 Bilateral procedure.

Respiratory System/Incision

- 32097 Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral

AAPC Rationale

Code 32097 is one of three new codes created to provide more detail for the type of tissue biopsied during a thoracotomy. The procedure is reported once per lung, regardless of the number of biopsies performed. When performed on both lungs, append modifier 50 Bilateral procedure.

Respiratory System/Incision

- 32098 Thoracotomy, with biopsy(ies) of pleura

AAPC Rationale

Code 32098 is one of three new codes created to provide more detail for the type of tissue biopsied during a thoracotomy. The procedure is reported once per lung, regardless of the number of biopsies performed. When performed on both lungs, append modifier 50 Bilateral procedure.
AAPC Rationale
Code 32098 is one of three new codes created to provide more detail for the type of tissue biopsied during a thoracotomy. The procedure is reported once, regardless of the number of biopsies performed.

Respiratory System/Incision
▲ 32100 Thoracotomy, major, with exploration and biopsy

AAPC Rationale
Descriptor language for 32100–32160 has been revised (deleting "major") for consistency. Code 32100 was also revised to remove "and biopsy;" to report biopsy(ies) performed by thoracotomy, see 32096–32098.

Respiratory System/Incision
▲ 32110 Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear

AAPC Rationale
Descriptor language for 32100–32160 has been revised (deleting "major") for consistency.

Respiratory System/Incision
▲ 32120 Thoracotomy, major; for postoperative complications

AAPC Rationale
Descriptor language for 32100–32160 has been revised (deleting "major") for consistency.

Respiratory System/Incision
▲ 32124 Thoracotomy, major, with open intrapleural pneumonolysis

AAPC Rationale
Descriptor language for 32100–32160 has been revised (deleting "major") for consistency.

Respiratory System/Incision
▲ 32140 Thoracotomy, major, with cyst(s) removal, with or without a includes pleural procedure when performed

AAPC Rationale
Descriptor language for 32100–32160 has been revised (deleting "major") for consistency; 32140 was further revised to include the inclusion of pleural procedures, when performed.

Respiratory System/Incision
▲ 32141 Thoracotomy, major, with excision-resection-pllication of bullae, with or without includes any pleural procedure when performed

AAPC Rationale
Descriptor language for 32100–32160 has been revised (deleting "major") for consistency. 32141 was further revised to include the inclusion of pleural procedures, when performed.

Respiratory System/Incision
▲ 32150 Thoracotomy, major, with removal of intrapleural foreign body or fibrin deposit

AAPC Rationale
Descriptor language for codes 32100–32160 has been revised (deleting "major") for consistency.

Respiratory System/Incision
▲ 32151 Thoracotomy, major, with removal of intrapulmonary foreign body

AAPC Rationale
Descriptor language for codes 32100–32160 has been revised (deleting "major") for consistency.

Respiratory System/Incision
▲ 32160 Thoracotomy, major; with cardiac massage

AAPC Rationale
Descriptor language for codes 32100–32160 has been revised (deleting "major") for consistency.

Respiratory System/Excision
32402 Biopsy, pleura; open

AAPC Rationale
Code 32402 has been deleted; see new code 32098.

Respiratory System/Excision
▲ ♦ 32405 Biopsy, lung or mediastinum, percutaneous needle

AAPC Rationale
Biopsy of lung, as described by 32405, now includes moderate sedation, when performed.
Respiratory System/Removal

▲ 32440 Removal of lung, total pneumonectomy;

AAPC Rationale
Descriptor language for 32440–32445 and 32480–32491 has been revised (deleting “total”) for consistency with new codes created for lung excisions.

Respiratory System/Removal

▲ 32442 Removal of lung, total pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)

AAPC Rationale
Descriptor language for 32440–32445 and 32480–32491 has been revised (deleting “total”) for consistency with new codes created for lung excisions.

Respiratory System/Removal

▲ 32445 Removal of lung, total pneumonectomy; extrapleural

AAPC Rationale
Descriptor language for 32440–32445 and 32480–32491 has been revised (deleting “total”) for consistency with new codes created for lung excisions.

Respiratory System/Removal

▲ 32480 Removal of lung, other than total pneumonectomy; single lobe (lobectomy)

AAPC Rationale
Descriptor language for 32440–32445 and 32480–32491 has been revised (deleting “total”) for consistency with new codes created for lung excisions.

Respiratory System/Removal

▲ 32482 Removal of lung, other than total pneumonectomy; 2 lobes (bilobectomy)

AAPC Rationale
Descriptor language for 32440–32445 and 32480–32491 has been revised (deleting “total”) for consistency with new codes created for lung excisions.

Respiratory System/Removal

▲ 32484 Removal of lung, other than total pneumonectomy; single segment (segmentectomy)

AAPC Rationale
Descriptor language for 32440–32445 and 32480–32491 has been revised (deleting “total”) for consistency with new codes created for lung excisions.

Respiratory System/Removal

▲ 32486 Removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)

AAPC Rationale
Descriptor language for 32440–32445 and 32480–32491 has been revised (deleting “total”) for consistency with new codes created for lung excisions.

Respiratory System/Removal

▲ 32488 Removal of lung, other than total pneumonectomy; with all remaining lung following previous removal of a portion of lung (completion pneumonectomy)

AAPC Rationale
Descriptor language for 32440–32445 and 32480–32491 has been revised (deleting “total”) for consistency with new codes created for lung excisions.

Respiratory System/Removal

▲ 32491 Removal of lung, other than total pneumonectomy; excision with resection–plication of emphysematous lung(s) (bullaous or non-bullaous) for lung volume reduction, sternal split or transthoracic approach with or without includes any pleural procedure, when performed

AAPC Rationale
Descriptor language for 32440–32445 and 32480–32491 has been revised (deleting “total”) for consistency with new codes created for lung excisions; 32491 was further revised to include pleural procedures, when performed.

Respiratory System/Removal

32500 Removal of lung, other than total pneumonectomy; wedge resection, single or multiple
AAPC Rationale
Code 32500 has been deleted; see new codes 32505–32507.

Respiratory System/Removal
- 32505 Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial

AAPC Rationale
Code 32505 was created to report an initial therapeutic wedge resection performed via thoracotomy. Do report 32505 with lung removal procedures 32440, 32442, 32445, and 32488.

Respiratory System/Removal
- +32506 Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)

AAPC Rationale
Code 32506 is an add-on code created to report each additional wedge resection. This code is to be used only with 32505.

Respiratory System/Removal
- +32507 Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)

AAPC Rationale
Code 32507 is an add-one created to report a diagnostic wedge resection when performed with other procedures. In CPT®, a parenthetical note following 32507 lists the appropriate primary procedures as pneumonectomy (32440, 32442, 32445), other lung removal (32480, 32482, 32484, 32486, 32488), and bronchoplasty (32503, 32504).

Respiratory System/Endoscopy
▲ 32601 Thoracoscopy, diagnostic (separate procedure); lungs and pericardial sac, mediastinal or pleural space, without biopsy

AAPC Rationale
The heading of subsection (32601–32674) was revised to accurately describe the techniques used during Video-assisted Thoracic Surgery (VATS). Code 32601 was revised to include the “pericardial sac, mediastinal or pleural space.”

This code is reported for a diagnostic VATS thoracoscopy, including biopsy.

Respiratory System/Endoscopy
32602 Thoracoscopy, diagnostic (separate procedure), lungs and pleural space, with biopsy

AAPC Rationale
Code 32602 has been deleted; see new codes 32607-32609.

Respiratory System/Endoscopy
32603 Thoracoscopy, diagnostic (separate procedure), pericardial sac, without biopsy

AAPC Rationale
Code 32603 has been deleted; see revised code 32601.

Respiratory System/Endoscopy
32605 Thoracoscopy, diagnostic (separate procedure); mediastinal space, without biopsy

AAPC Rationale
Code 32605 has been deleted; see revised code 32601.

Respiratory System/Endoscopy
- 32607 Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral

AAPC Rationale
Code 32607 is one of three new codes created to provide more detail for the type of tissue biopsied during a VATS thoracoscopy. The procedure is reported once per lung, regardless of the number of biopsies performed.

Respiratory System/Endoscopy
- 32608 Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral

AAPC Rationale
Code 32608 is one of three new codes created to provide more detail for the type of tissue biopsied during a VATS thoracoscopy. The procedure is reported once per lung, regardless of the number of biopsies performed.
Respiratory System/Endoscopy
● 32609 Thoracoscopy; with biopsy(ies) of pleura

AAPC Rationale
Code 32609 is one of three new codes created to provide more detail for the type of tissue biopsied during a VATS thoracoscopy. The procedure is reported once, regardless of the number of biopsies performed.

Respiratory System/Endoscopy
▲ 32655 Thoracoscopy, surgical; with excision-resection-plication of bullae, including includes any pleural procedure when performed

AAPC Rationale
Descriptor language for 32655 has been revised (changing “excision” to “resection”) for consistency. The code also includes pleural procedures, when performed.

Respiratory System/Endoscopy
32657 Thoracoscopy, surgical; with wedge resection of lung—single or multiple

AAPC Rationale
Code 32657 has been deleted; see new codes 32666, 32667, 32668.

Respiratory System/Endoscopy
32660 Thoracoscopy, surgical; with total pericardiectomy

AAPC Rationale
Code 32660 was deleted because the procedure is no longer performed.

Respiratory System/Endoscopy
▲ 32663 Thoracoscopy, surgical; with lobectomy—total or segmental (single lobe)

AAPC Rationale
Descriptor language for code 32663 has been revised (deleting “total”) for consistency with new codes created for lung excisions.

Respiratory System/Endoscopy
● 32666 Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral

AAPC Rationale
Code 32666 was created to report an initial therapeutic wedge resection performed via VATS thoracoscopy. Do not to report 32666 with lung removal procedures 32440, 32442, 32445, 32488, and 32671.

Respiratory System/Endoscopy
● +32667 Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)

AAPC Rationale
Code 32667 is an add-on created to report each additional wedge resection. Use 32667 only in addition to 32666.

Respiratory System/Endoscopy
+32667 Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)

AAPC Rationale
Code 32668 is an add-one created to report a diagnostic wedge resection when performed with other procedures. Primary procedures may include lung removal (32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488), tumor resection (32503, 32504), and thoracoscopy with lobectomy, wedge resection, or removal of flung segment(s) (32663, 32669, 32670, 32671).

Respiratory System/Endoscopy
● 32669 Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)

AAPC Rationale
Codes 32669–32674 were created to report removal procedures performed via VATS thoracoscopy. The codes are selected based on the type or amount of tissue removed, or the difficulty of the procedure.

Code 32669 is reported when a single lung segment is removed.

Respiratory System/Endoscopy
● 32670 Thoracoscopy, surgical; with removal of two lobes (bilobectomy)
AAPC Rationale
Codes 32669–32674 were created to report removal procedures performed via VATS thoracoscopy. The codes are selected based on the type or amount of tissue removed, or the difficulty of the procedure.

Code 32670 is reported when two lobes are removed.

Respiratory System/Endoscopy
• 32671 Thoracoscopy, surgical; with removal of lung (pneumonectomy)

AAPC Rationale
Codes 32669–32674 were created to report removal procedures performed via VATS thoracoscopy. The codes are selected based on the type or amount of tissue removed, or the difficulty of the procedure.

Code 32671 is reported when an entire lung is removed.

Respiratory System/Endoscopy
• 32672 Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed

AAPC Rationale
Codes 32669–32674 were created to report removal procedures performed via VATS thoracoscopy. The codes are selected based on the type or amount of tissue removed, or the difficulty of the procedure.

Code 32672 is reported for the resection of an emphysematous lung. This procedure includes procedures performed on the pleura.

Respiratory System/Endoscopy
• 32673 Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral

AAPC Rationale
Codes 32669–32674 were created to report removal procedures performed via VATS thoracoscopy. The codes are selected based on the type or amount of tissue removed, or the difficulty of the procedure.

Code 32673 is reported for the resection of the thymus.

Respiratory System/Endoscopy
• +32674 Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 32669–32674 were created to report removal procedures performed via VATS thoracoscopy. The codes are selected based on the type or amount of tissue removed, or the difficulty of the procedure.

Code 32674 is add-on for mediastinal and regional lymphadenectomy when performed with another procedure. A parenthetical note in CPT® lists primary procedure codes with which you may report 32674.

Cardiovascular System/Heart and Pericardium
▲ 33050 Excision/Resection of pericardial cyst or tumor

AAPC Rationale
Code 33050 was revised for consistency in coding excisions. Parenthetical notes were added to direct the coder to the proper codes when the procedure is performed via VATS.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator
▲ ⊗ 33206 Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial

AAPC Rationale
Descriptor language for codes 33206–33208 has been revised (adding “new”) for consistency.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.
Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

▲ 33207 Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular

AAPC Rationale
Descriptor language for codes 33206–33208 has been revised (adding “new”) for consistency.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

▲ 33208 Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular

AAPC Rationale
Descriptor language for codes 33206–33208 has been revised (adding “new”) for consistency.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

▲ 33212 Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular with existing single lead

AAPC Rationale
Descriptor language for codes 33212–33213 has been revised (deleting “or replacement”) and adding the correct terminology for the type of lead.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

▲ 33213 Insertion or replacement of pacemaker pulse generator only; with existing dual chamber leads

AAPC Rationale
Descriptor language for codes 33212–33213 has been revised (deleting “or replacement”) and adding the correct terminology for the type of lead.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

▲ 33218 Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator

AAPC Rationale
Descriptor language for code 33218 has been revised (deleting “single chamber”) for consistency with the terminology in this subsection.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

▲ 33220 Repair of 2 transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator

AAPC Rationale
Descriptor language for code 33220 has been revised (deleting “dual chamber”) for consistency with the terminology in this subsection.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.
Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

- # 33221 Insertion of pacemaker pulse generator only; with existing multiple leads

**AAPC Rationale**

Code 33221 was created to report the insertion of pacemaker pulse generator using existing multiple leads.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

- ▲ 33224 Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)

**AAPC Rationale**

Descriptor language for code 33224 has been revised (adding “existing”) for consistency with the terminology in this subsection.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

- ▲ 33226 Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)

**AAPC Rationale**

Descriptor language for code 33226 has been revised (adding “existing”) for consistency with the terminology in this subsection.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

- ▲ 33233 Removal of permanent pacemaker pulse generator only

**AAPC Rationale**

Descriptor language for code 33233 has been revised (adding “only”) to clarify that only the pulse generator is removed.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

- ▲ 33225 Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system and pocket revision) (List separately in addition to code for primary procedure)

**AAPC Rationale**

Descriptor language for code 33225 has been revised (adding “and pocket revision”) to clarify that pocket revision is included and not reported separately.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.
Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator
● # ☰ 33227 Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system

AAPC Rationale
Three new codes were created to include the removal and replacement of the pacemaker pulse generator; 33227 is reported for a single lead system. Do not report the removal of the pulse generator separately.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator
● # ☰ 33228 Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system

AAPC Rationale
Three new codes were created to include the removal and replacement of the pacemaker pulse generator; 33228 is reported for a dual lead system. Do not report the removal of the pulse generator separately.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator
● # ☰ 33229 Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system

AAPC Rationale
Three new codes were created to include the removal and replacement of the pacemaker pulse generator; 33229 is reported for a multiple lead system. Do not report the removal of the pulse generator separately.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator
▲ ☰ 33240 Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator only; with existing single lead

AAPC Rationale
Descriptor language for 33240 has been revised (deleting “single or dual” and adding “only; with existing single lead”) for consistency. Prior to 2012, only one code was available to report the insertion of a pacing cardioverter-defibrillator pulse generator. The revision of 33240 was required to accommodate two new codes (33230, 33231) to report the procedure for dual and multiple leads systems.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator
● # ☰ 33230 Insertion of pacing cardioverter-defibrillator pulse generator only; with existing dual leads

AAPC Rationale
Code 33240 has been revised and two new codes (33230, 33231) created to report the insertion of a pacing cardioverter-defibrillator pulse generator using existing leads; 33230 is reported when the procedure involves a dual lead system.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.
Complete 2012 Procedure Updates

Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

- # ○ 33231 Insertion of pacing cardioverter-defibrillator pulse generator only; with existing multiple leads

**AAPC Rationale**

Code 35240 has been revised and two new codes (33230, 33231) created to report the insertion of a pacing cardioverter-defibrillator pulse generator using existing leads; 33231 is reported when the procedure involves a multiple lead system.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

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Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

- ▲ ○ 33241 Subcutaneous removal Removal of single or dual chamber pacing cardioverter-defibrillator pulse generator only

**AAPC Rationale**

Descriptor language for code 33241 has been revised (deleting “Subcutaneous, single or dual chamber” and adding “only”) for consistency with the terminology in this subsection; 33241 is reported for the removal of a pacing cardioverter-defibrillator pulse generator for all three types of systems (single, dual, or multiple lead).

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

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Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

- # ○ 33262 Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system

**AAPC Rationale**

Three new codes were created to report the removal and replacement of a pacing cardioverter-defibrillator pulse generator. The code is selected based on the type of system; 33262 is reported for a single lead system. Do not report the removal of the pulse generator separately.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

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Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

- # ○ 33263 Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system

**AAPC Rationale**

Three new codes were created to report the removal and replacement of a pacing cardioverter-defibrillator pulse generator. The code is selected based on the type of system; 33263 is reported for a dual lead system. Do not report the removal of the pulse generator separately.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

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Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

- # ○ 33264 Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system

**AAPC Rationale**

Three new codes were created to report the removal and replacement of a pacing cardioverter-defibrillator pulse generator. The code is selected based on the type of system; 33264 is reported for a multiple lead system. Do not report the removal of the pulse generator separately.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.
Cardiovascular System/Pacemaker or Pacing Cardioverter-Defibrillator

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>AAPC Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲ 33249 Insertion or repositioning, replacement of electrode-permanent pacing cardioverter-defibrillator system with transvenous lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AAPC Rationale
Descriptor language for code 33249 has been revised (deleting “repositioning, electrode” and adding “replacement, permanent”) for consistency with the terminology in this subsection; 33249 is reported for the insertion or replacement of the pacing cardioverter-defibrillator pulse generator and leads for a single or dual lead system.

Coding guidelines for 33206–33249 have been revised to include radiologic supervision and interpretation. Fluoroscopy (76000) can be reported only when performed for diagnostic lead evaluation without lead insertion, replacement, or revisions.

Cardiovascular System/Cardiac Assist

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>AAPC Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲ 33960 Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours</td>
<td></td>
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</tbody>
</table>

AAPC Rationale
Descriptor language for 33960 was revised to clarify that the code should be reported for the date of service, not a 24-hour period.

Cardiovascular System/Cardiac Assist

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>AAPC Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲ 33961 Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each additional 24 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AAPC Rationale
Descriptor language for 33961 was revised to clarify that the code should be reported for each subsequent date of service, and not each additional 24-hour period.

Cardiovascular System/Bypass Graft

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>AAPC Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>35548 Bypass graft, with vein; aortoiliac, unilateral</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AAPC Rationale
Code 35548 was deleted; see codes 35537, 35539, 35565. Code determination is based on the vessels involved with the bypass graft.

Cardiovascular System/Bypass Graft

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>AAPC Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>35549 Bypass graft, with vein; aortoiliac, bilateral</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AAPC Rationale
Code 35549 was deleted; see codes 35537, 35538, 35539, 35540, 35565. Code determination is based on the vessels involved with the bypass graft.

Cardiovascular System/Bypass Graft

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>AAPC Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>35551 Bypass graft, with vein; aortoiliac-popliteal</td>
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</tbody>
</table>

AAPC Rationale
Code 35551 was deleted; see codes 35539, 35540, 35556, 35583. Code determination is based on the vessels involved with the bypass graft.

Cardiovascular System/Bypass Graft

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>AAPC Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>35651 Bypass graft, with other than vein; aortoiliac-popliteal</td>
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</tbody>
</table>

AAPC Rationale
Code 35651 was deleted; see codes 35646, 35647, 35656. Code determination is based on the vessels involved with the bypass graft.

Cardiovascular System/Vascular Injection Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>AAPC Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲ 36200 Introduction of catheter, aorta</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AAPC Rationale
Introduction of catheter now includes moderate sedation, when performed.

Cardiovascular System/Vascular Injection Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>AAPC Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲ 36245 Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AAPC Rationale
Codes 36245–36248 for selective catheter placement, arterial system of the abdomen, pelvis, and lower extremity now include moderate sedation, when performed.
Cardiovascular System/Vascular Injection Procedures

▲ ○ 36246 Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family

AAPC Rationale
Codes 36245–36248 for selective catheter placement, arterial system of the abdomen, pelvis, and lower extremity now include moderate sedation, when performed.

Cardiovascular System/Vascular Injection Procedures

▲ ○ 36247 Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family

AAPC Rationale
Codes 36245–36248 for selective catheter placement, arterial system of the abdomen, pelvis, and lower extremity now include moderate sedation, when performed.

Cardiovascular System/Vascular Injection Procedures

▲ ○ 36248 Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (list in addition to code for initial second or third order vessel as appropriate

AAPC Rationale
Codes 36245–36248 for selective catheter placement, arterial system of the abdomen, pelvis, and lower extremity now include moderate sedation, when performed.

Cardiovascular System/Vascular Injection Procedures

● ○ 36251 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

AAPC Rationale
Four new codes (36251–36254) were created to report renal catheterization and angioplasty. The AMA/Specialty Society RVS Update Committee (RUC) determined that these services were reported together at least 75 percent of the time. The new codes include “arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images and radiologic supervision and interpretation.”

Code 36251 is reported for first order selective renal catheterization and angioplasty performed unilaterally.

Cardiovascular System/Vascular Injection Procedures

● ○ 36252 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral

AAPC Rationale
Four new codes (36251–36254) were created to report renal catheterization and angioplasty. The AMA/Specialty Society RVS Update Committee (RUC) determined that these services were reported together at least 75 percent of the time. The new codes include “arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images and radiologic supervision and interpretation.”

Code 36252 is reported for first order selective renal catheterization and angioplasty performed bilaterally.

Cardiovascular System/Vascular Injection Procedures

● ○ 36253 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image post processing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral
AAPC Rationale
Four new codes (36251–36254) were created to report renal catheterization and angioplasty. The AMA/Specialty Society RVS Update Committee (RUC) determined that these services were reported together at least 75 percent of the time. The new codes include “arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images and radiologic supervision and interpretation.”

Code 36253 is reported for one or more second or higher order superselective renal catheterization and angioplasty, performed unilaterally.

Cardiovascular System/Vascular Injection Procedures
- 36254 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral

AAPC Rationale
Four new codes (36251–36254) were created to report renal catheterization and angioplasty. The AMA/Specialty Society RVS Update Committee (RUC) determined that these services were reported together at least 75 percent of the time. The new codes include “arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images and radiologic supervision and interpretation.”

Code 36254 is reported for one or more second or higher order superselective renal catheterization and angioplasty, performed bilaterally.

Cardiovascular System/Transcatheter Procedures
- 37191 Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

AAPC Rationale
With the deletion of code 37620 and 75940, three new codes (37191–37193) were created to report procedures for intravascular vena cava filters. The new codes include the radiological supervision and interpretation and imaging guidance, when performed.

Code 37191 is reported for the insertion of an intravascular vena cava filter.

Cardiovascular System/Transcatheter Procedures
- 37192 Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

AAPC Rationale
With the deletion of code 37620 and 75940, three new codes (37191–37193) were created to report procedures for intravascular vena cava filters. The new codes include the radiological supervision and interpretation and imaging guidance, when performed.

Code 37192 is reported for the repositioning of an intravascular vena cava filter.

Cardiovascular System/Transcatheter Procedures
- 37193 Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

AAPC Rationale
With the deletion of code 37620 and 75940, three new codes (37191–37193) were created to report procedures for intravascular vena cava filters. The new codes include the radiological supervision and interpretation and imaging guidance, when performed.

Code 37193 is reported for the removal of an intravascular vena cava filter.
Cardiovascular System/Ligation

- 37619 Ligation of inferior vena cava

**AAPC Rationale**

With the deletion of 37620 and 75940, 37619 was created to report the ligation of the inferior vena cava.

Cardiovascular System/Ligation

37620 Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)

**AAPC Rationale**

Code 37620 was deleted; see new codes 37191, 37619.

Hemic and Lymphatic Systems/Bone Marrow or Stem Cell Services-Procedures

- 38208 Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor

**AAPC Rationale**

Descriptor language for codes 38208–38209 has been revised (adding “per donor”) to allow for multiple units to be reported when multiple blood cord units are required.

- 38209 Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor

**AAPC Rationale**

Descriptor language for codes 38208–38209 has been revised (adding “per donor”) to allow for multiple units to be reported when multiple blood cord units are required.

Hemic and Lymphatic Systems/Bone Marrow or Stem Cell Services-Procedures

- 38230 Bone marrow harvesting for transplantation; allogenic

**AAPC Rationale**

Allogenic tissues are of the same species but genetically dissimilar/immunologically incompatible. Descriptor language was revised to distinguish 38230 from new code 38232 which describes autologous tissue.

- 38232 Bone marrow harvesting for transplantation; autologous

**AAPC Rationale**

Autologous tissues are obtained from the same individual; 38230 has been revised and 38232 created to distinguish between an allogenic bone marrow harvest and autologous bone marrow harvest.

Hemic and Lymphatic Systems/Introduction

- 38792 Injection procedure; radioactive tracer for identification of sentinel node

**AAPC Rationale**

Descriptor language for code 38792 has been revised (adding “radioactive tracer”). This code is reported only when injection of a radiotracer is performed.

Mediastinum and Diaphragm/Excision

- 39200 Excision Resection of mediastinal cyst

**AAPC Rationale**

Descriptor language for 39200 has been revised (deleting “excision” and adding “resection”) for consistency.

- 39220 Excision Resection of mediastinal tumor

**AAPC Rationale**

Descriptor language for 39220 has been revised (deleting “excision” and adding “resection”) for consistency.
Mediastinum and Diaphragm/Endoscopy

- 39400 Mediastinoscopy, with or without biopsy includes biopsy(ies), when performed

AAPC Rationale
Descriptor language for 39400 has been revised to indicate that the procedure includes biopsy(ies), when performed. This code is reported one time regardless of the number of biopsies performed.

Digestive System/Liver/Incision

- 47000 Biopsy of liver, needle; percutaneous

AAPC Rationale
Percutaneous needle biopsy of liver, as reported with 47000, now includes moderate sedation. This is the only change to the code.

Digestive System/abdomen, Peritoneum, and Omentum/Incision

- 49080 Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial

AAPC Rationale
Code 49080 has been deleted; to report peritoneocentesis/paracentesis see new codes 49082–49083.

Digestive System/abdomen, Peritoneum, and Omentum/Incision

- 49081 Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent

AAPC Rationale
Code 49081 has been deleted; to report peritoneocentesis/paracentesis see new codes 49082–49083.

Digestive System/abdomen, Peritoneum, and Omentum/Incision

- 49082 Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance

AAPC Rationale
New code 49082 describes abdominal paracentesis without imaging guidance. During this procedure, a needle is used to remove a sample of fluid or to drain fluid that has accumulated in the abdomen. To report abdominal paracentesis with imaging guidance, see 49083.

Digestive System/abdomen, Peritoneum, and Omentum/Incision

- 49083 Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance

AAPC Rationale
New code 49083 describes abdominal paracentesis with imaging guidance. During this procedure, a needle is used to remove a sample of fluid or to drain fluid that has accumulated in the abdomen. Do not separately report imaging guidance (eg, 76942, 77002, 77012, or 77021) with 49083. To report abdominal paracentesis without imaging guidance, see 49082.

Surgery/Nervous System

Nervous System/Spine and Spinal Cord/Injection, Drainage, or Aspiration

- 62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method single utilizing needle based technique to remove disc material under fluoroscopic imaging or multiple levels other form of indirect visualization, lumbar (eg, with the use of an endoscope, manual with discography and/or automated percutaneous discectomy, epidural injection(s) at the treated level(s), when performed, percutaneous laser discectomy) single or multiple levels, lumbar

AAPC Rationale
With the addition of new Cat. III codes 0274T and 0275T Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral
or bilateral... to describe non-needle based percutaneous decompression of nucleus pulposus of intervertebral disc, 62287 has been revised to clearly identify it as a needle-based procedure with endoscopic approach, also distinct from an open approach. The procedure removes part of the nucleus pulposus (the gel center) from a ruptured disk, to decrease pressure on a spinal nerve root and relieve pain.

Code 62287 includes fluoroscopic imaging or other indirect visualization; do not report such imaging (e.g., 77003, 77012, 77295) when performed at the same level. Do not report percutaneous aspiration with the nucleus pulposus (62267) differentiation injection (62290), or diagnostic/therapeutic lumbar injection (62311) in addition to 62287.

Nervous System/Spine and Spinal Cord/Injection, Drainage, or Aspiration

AAPC Rationale

Descriptor language for 62310 has been revised for clarity. The code is reported when a catheter is placed to administer an epidural or subarachnoid injection(s) on a single day. Injections at one or more lumbar or sacral levels are counted as a single unit of 62311. Fluoroscopy, if used, may be separately reported with 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraaxial diagnostic or therapeutic injection procedures (epidural or subarachnoid).

For cervical or thoracic injections, see 62310. For injections spanning several days, see 62318–62319.

Nervous System/Spine and Spinal Cord/Injection, Drainage, or Aspiration

AAPC Rationale

Descriptor language for 62318 has been revised for clarity. The code is reported when a catheter is placed to administer an epidural or subarachnoid injection(s) over an extended period (e.g., two or more days), either continuously or via intermittent bolus. Injections at one or more cervical or thoracic levels are counted as a single unit of 62318. Fluoroscopy, if used, may be separately reported with 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraaxial diagnostic or therapeutic injection procedures (epidural or subarachnoid).

For lumbar or sacral injections, see 62311. For injections spanning several days, see 62318–62319.
AAPC Rationale
Descriptor language for 62319 has been revised for clarity. The code is reported when a catheter is placed to administer an epidural or subarachnoid injection(s) over an extended period (eg, two or more days), either continuously or via intermittent bolus. Injections at one or more lumbar or sacral levels are counted as a single unit of 62319. Fluoroscopy, if used, may be separately reported with 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid).

For cervical or thoracic injections, see 62318. For injections on a single day, see 62310–62311.

Nervous System/Spine and Spinal Cord/Reservoir-Pump Implantation
▲ 62367 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill

AAPC Rationale
The descriptor for 62367 has been revised to specify that the code applies for electronic analysis of implantable pump without pump reprogramming or refill. To report analysis with reprogramming but without refill, see 62368 (this code is unchanged from last year). To report analysis with reprogramming and refill, see new code 62369.

Do not report 62367 with 95990 or 95991, which describe refilling and maintenance of a reservoir or an implantable infusion pump for spinal or brain drug delivery without reprogramming.

Nervous System/Spine and Spinal Cord/Reservoir-Pump Implantation
● 62369 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill

AAPC Rationale
Like new code 62369, 62370 describes electronic analysis of implantable pump (eg, for intrathecal or epidural drug infusion) with pump reprogramming and refill; however, 62370 should be reported when the service specifically requires a physician’s skill. Documentation should support the need for physician skill, and that the physician provided the service.

For electronic analysis of an implanted pump without reprogramming and refill, see revised code 62367. For analysis with reprogramming but without refill, see 62368.

Do not report 62370 with 95990 or 95991, which describe refilling and maintenance of a reservoir or an implantable infusion pump for spinal or brain drug delivery without reprogramming.

Nervous System/Spine and Spinal Cord/Posterior Extradural Laminotomy or Laminectomy for Exploration-Decompression of Neural Elements or Excision of Herniated Intervertebral Discs
▲ 63020 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc(s), including open and endoscopically-assisted approaches; 1 interspace, cervical

AAPC Rationale
New section guidelines specify that endoscopically assisted laminotomy requires open and direct visualization; there-
fore, the descriptors for 63020—63035 have been revised to eliminate the reference to “open and endoscopically-assisted” procedures (which is made redundant by the new guidelines). Laminotomy requiring only endoscopic and/or image guidance is by definition percutaneous, and should be reported using Cat. III codes 0274T and 0275T Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, disectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral.

Nervous System/Spine and Spinal Cord/Posterior Extradoxal Laminectomy or Laminectomy for Exploration-Decompression of Neural Elements or Excision of Herniated Intervertebral Discs

AAPC Rationale
New section guidelines specify that endoscopically assisted laminotomy requires open and direct visualization; therefore, the descriptors for 63020—63035 have been revised to eliminate the reference to “open and endoscopically-assisted” procedures (which is made redundant by the new guidelines). Laminotomy requiring only endoscopic and/or image guidance is by definition percutaneous, and should be reported using Cat. III codes 0274T and 0275T Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, disectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Neurostimulators (Peripheral Nerve)

AAPC Rationale
The term “array” has been added for clarity, to ensure proper code application. Implanted neurostimulators typically contain multiple (usually four to eight) electrodes. CPT® specifically defines an electrode array as “a catheter or other device with more than one contact.” The code should be applied once per array, not once per electrode. For example, if an implanted array includes four electrodes, proper coding is 64553, not 64553 x 4.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Neurostimulators (Peripheral Nerve)

AAPC Rationale
The term “array” has been added for clarity, to ensure proper code application. Implanted neurostimulators typically contain multiple (usually four to eight) electrodes. CPT® specifically defines an electrode array as “a catheter or other device with more than one contact.” The code should be
applied once per array, not once per electrode. For example, if a single implanted array includes eight electrodes, proper coding is 64555, not 64555 x 8.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Neurostimulators (Peripheral Nerve)

64560 Percutaneous implantation of neurostimulator electrodes; autonomic nerve

AAPC Rationale
Code 64560 has been deleted as obsolete.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Neurostimulators (Peripheral Nerve)

▲ 64561 Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)

AAPC Rationale
The term “array” has been added for clarity, to ensure proper code application. Implanted neurostimulators typically contain multiple (usually four to eight) electrodes. CPT® specifically defines an electrode array as “a catheter or other device with more than one contact.” The code should be applied once per array, not once per electrode. For example, if a single implanted array includes four electrodes, proper coding is 64561, not 64561 x 4.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Neurostimulators (Peripheral Nerve)

▲ 64565 Percutaneous implantation of neurostimulator electrode array; neuromuscular

AAPC Rationale
The term “array” has been added for clarity, to ensure proper code application. Implanted neurostimulators typically contain multiple (usually four to eight) electrodes. CPT® specifically defines an electrode array as “a catheter or other device with more than one contact.” The code should be applied once per array, not once per electrode. For example, if a single implanted array includes eight electrodes, proper coding is 64565, not 64565 x 8.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Neurostimulators (Peripheral Nerve)

▲ 64575 Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)

AAPC Rationale
The term “array” has been added for clarity, to ensure proper code application. Implanted neurostimulators typically contain multiple (usually four to eight) electrodes. CPT® specifically defines an electrode array as “a catheter or other device with more than one contact.” The code should be applied once per array, not once per electrode. For example, if a single implanted array includes four electrodes, proper coding is 64575, not 64575 x 4.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Neurostimulators (Peripheral Nerve)

▲ 64577 Incision for implantation of neurostimulator electrode array; autonomic nerve

AAPC Rationale
Code 64577 has been deleted as obsolete.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Neurostimulators (Peripheral Nerve)

▲ 64580 Incision for implantation of neurostimulator electrode array; neuromuscular

AAPC Rationale
The term “array” has been added for clarity, to ensure proper code application. Implanted neurostimulators typically contain multiple (usually four to eight) electrodes. CPT® specifically defines an electrode array as “a catheter or other device with more than one contact.” The code should be applied once per array, not once per electrode. For example, if a single implanted array includes four electrodes, proper coding is 64580, not 64580 x 4.
Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Neurostimulators (Peripheral Nerve)

64581 Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)

AAPC Rationale
The term “array” has been added for clarity, to ensure proper code application. Implanted neurostimulators typically contain multiple (usually four to eight) electrodes. CPT® specifically defines an electrode array as “a catheter or other device with more than one contact.” The code should be applied once per array, not once per electrode. For example, if a single implanted array includes eight electrodes, proper coding is 64581, not 64581 x 8.

64585 Revision or removal of peripheral neurostimulator electrode array

AAPC Rationale
The term “array” has been added for clarity, to ensure proper code application. Implanted neurostimulators typically contain multiple (usually four to eight) electrodes. CPT® specifically defines an electrode array as “a catheter or other device with more than one contact.” The code should be applied once per array, not once per electrode. For example, if a single implanted array includes four electrodes, proper coding is 64585, not 64585 x 4.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency)

64622 Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level

AAPC Rationale
Codes 64622–64627 have been deleted and replaced by new codes 64633–64636.

64623 Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 64622–64627 have been deleted and replaced by new codes 64633–64636.

64626 Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level

AAPC Rationale
Codes 64622–64627 have been deleted and replaced by new codes 64633–64636.

64627 Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

AAPC Rationale
Codes 64622–64627 have been deleted and replaced by new codes 64633–64636.
Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency)

- # 64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

AAPC Rationale
With the deletion of 64623–64627, CPT® has created four new codes (64633–64636) to describe paravertebral facet joint injections. The new codes (unlike the previous codes) specifically include imaging guidance. Do not report 64633–64636 with imaging procedures 77003 Fluoroscopic guidance… or 77012 Computed tomography guidance….

Code 64633 describes injection of a single, initial cervical or thoracic facet joint. Count only the number of facet joints injected, not individual injections. If the physician injects the same facet joint multiple times, claim just a single unit of service. For injection of additional cervical or thoracic facet joints, beyond the first, see add-on 64634; however, you may append modifier 50 Bilateral procedure for bilateral injections. For lumbar or sacral facet joint injections, see 64635–64636.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency)

- # +64634 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)

AAPC Rationale
With the deletion of 64623–64627, CPT® has created four new codes (64633–64636) to describe paravertebral facet joint injections. The new codes (unlike the previous codes) specifically include imaging guidance. Do not report 64633–64636 with imaging procedures 77003 Fluoroscopic guidance… or 77012 Computed tomography guidance….

Add-on 64634 describes injection of each additional cervical or thoracic facet joint, beyond the first: You must apply 64634 only in addition to initial facet joint injection code 64633. Count only the number of facet joints injected, not individual injections. If the physician injects the same facet joint multiple times, claim just a single unit of service; however, you may append modifier 50 Bilateral procedure for bilateral injections. For lumbar or sacral facet joint injections, see 64635–64636.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency)

- # 64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

AAPC Rationale
With the deletion of 64623–64627, CPT® has created four new codes (64633–64636) to describe paravertebral facet joint injections. The new codes (unlike the previous codes) specifically include imaging guidance. Do not report 64633–64636 with imaging procedures 77003 Fluoroscopic guidance… or 77012 Computed tomography guidance….

Code 64635 describes injection of a single, initial lumbar or sacral facet joint. Count only the number of facet joints injected, not individual injections. If the physician injects the same facet joint multiple times, claim just a single unit of service. For injection of additional cervical or thoracic facet joints, beyond the first, see add-on 64636; however, you may append modifier 50 Bilateral procedure for bilateral injections. For cervical or thoracic facet joint injections, see 64633–64634.

Nervous System/Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System/Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency)

- # +64636 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)

Add-on 64636 describes injection of each additional cervical or thoracic facet joint, beyond the first: You must apply 64636 only in addition to initial facet joint injection code 64633. Count only the number of facet joints injected, not individual injections. If the physician injects the same facet joint multiple times, claim just a single unit of service; however, you may append modifier 50 Bilateral procedure for bilateral injections. For lumbar or sacral facet joint injections, see 64635–64636.
AAPC Rationale
With the deletion of 64623–64627, CPT® has created four new codes (64633–64636) to describe paravertebral facet joint injections. The new codes (unlike the previous codes) specifically include imaging guidance. Do not report 64633–64636 with imaging procedures 77003 Fluoroscopic guidance… or 77012 Computed tomography guidance…

Add-on 64636 describes injection of each additional lumbar or sacral facet joint, beyond the first: You must apply 64636 only in addition to initial facet joint injection code 64635. Count only the number of facet joints injected, not individual injections. If the physician injects the same facet joint multiple times, claim just a single unit of service; however, you may append modifier 50 Bilateral procedure for bilateral injections. For cervical or thoracic facet joint injections, see 64633–64634.

AAPC Rationale
Auditory System/Inner Ear/Incision and-or Destruction

69802 Labyrinthotomy, with perfusion of vestibulotoxic drug(s), with mastoidectomy

AAPC Rationale
Code 69802 has been deleted as obsolete.

Radiology

Diagnostic Radiology/Head and Neck

70355 Orthopantogram (eg, panoramic X-ray)

AAPC Rationale
An orthopantogram (also: orthopantomogram (OPG) or panorex) is a panoramic dental X-ray of the upper and lower jaw, showing a two-dimensional view from ear to ear. The descriptor for 70355 now specifies “(eg., panoramic X-ray)” to better define the code and its use, which does not change from previous years.

Diagnostic Radiology/Chest

71090 Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation

AAPC Rationale
Code 71090 has been deleted: For pacemaker or pacing cardioverter-defibrillator lead insertion, replacement, or revision with guidance, see 33206–33249 (which now include fluoroscopy). For fluoroscopic guidance with diagnostic lead evaluation without insertion, replacement, or revision, see 76000 Fluoroscopy (separate procedure)…

Diagnostic Radiology/Spine and Pelvis

72114 Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views

AAPC Rationale
Bending films may help to differentiate structural from nonstructural curves of the spine, for instance in the diagnosis of scoliosis. The descriptor for 72114 has been revised to describe a “complete” examination as including a minimum of six views, with bending views. For bending views only (2–3 views), see 72120.

Diagnostic Radiology/Spine and Pelvis

72120 Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views

AAPC Rationale
Bending films may help to differentiate structural from nonstructural curves of the spine, for instance in the diagnosis of scoliosis. The descriptor for 72120 has been revised to describe two or three bending views only. For a complete exam, including bending views, see 72114.

Diagnostic Radiology/Lower Extremities

73542 Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation

AAPC Rationale
Arthrography is now an inclusive component of revised code 27096 Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed.

Diagnostic Radiology/Abdomen

74174 Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing

AAPC Rationale
Code 74174 has been added to describe a combined computed tomographic angiography (CTA) of the abdomen and CTA of the pelvis; these services are frequently performed together to visualize arterial and venous vessels. Do not
report individual studies (eg, 72191, 73706, 74175, 75635, 76376, 76377) in addition to 74174.

For CTA aorto-iliofemoral runoff, use 75635.

**Radiology/Vascular Procedures/Aorta and Arteries**

75722 Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation

**AAPC Rationale**

Code 75722 has been deleted; unilateral angiography is now bundled to new selective catheter placement codes 36251. Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral and 36253 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral.

75724 Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation

**AAPC Rationale**

Code 75724 has been deleted; bilateral angiography is now bundled to new selective catheter placement codes 36252. Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral and 36254 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral.

75940 Percutaneous placement of IVC filter, radiological supervision and interpretation

**AAPC Rationale**

Code 75940 has been deleted: Radiological supervision and interpretation is now an inclusive component of 37191 - Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intra procedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed.

75962 Transluminal balloon angioplasty, peripheral artery other than cervical carotid, renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation

**AAPC Rationale**

Descriptor language for 75962 has been revised to eliminate reference to the cervical carotid artery. This code describes radiological supervision and interpretation only; for transluminal angioplasty, see 35458 (open) and 35475 (percutaneous).

75964 Transluminal balloon angioplasty, each additional peripheral artery other than cervical carotid, renal, or other visceral artery, iliac and/or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)

**AAPC Rationale**

Descriptor language for 75964 has been revised to eliminate reference to the cervical carotid artery. As an add-on code, 75964 should be used in addition to primary supervision and interpretation (S&I) code 75962 for each additional iliac or lower extremity peripheral artery imaged, other then renal or other visceral artery. For transluminal angioplasty, see 35458 (open) and 35475 (percutaneous).
Radiologic Guidance/Fluoroscopic Guidance

▲ 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint-subarachnoid), including neurolytic agent destruction

AAPC Rationale
Imaging guidance is now an included component of destruction of facet joint nerves by neurolytic agent (ie, 27096, 64633–64636); the code descriptor for 77003 has been revised to reflect this change. Do not report 77003 in addition to 27096, injection of anesthetic agent/steroid 64479–64484, injection of diagnostic or therapeutic agent 64490–64495, or 64633–64636.

Other Radiologic Guidance/Bone-Joint Studies

77079 Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

AAPC Rationale
Code 77079 has been deleted as obsolete.

77083 Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites

AAPC Rationale
Code 77083 has been deleted as obsolete.

Radiation Treatment Management

● # 77424 Intraoperative radiation treatment delivery, X-ray, single treatment session

AAPC Rationale
Code 77424 (and codes 77425 and 77469) has been added to allow separate identification and reporting of intraoperative radiation treatment (IORT) delivery and management; 77424 specifically describes a single IORT treatment session using X-rays (for delivery using electrons, see 77425). IORT delivers high-dose radiation precisely to a targeted area while shielding surrounding tissue.

IORT services include simulations but do not include E/M services beyond the treatment management session (77469).

Previously, this service would have been reported using 77470 (revised for 2012).

Radiotherapy Treatment Management

● # 77425 Intraoperative radiation treatment delivery, electrons, single treatment session

AAPC Rationale
Code 77425 (and codes 77424 and 77469) has been added to allow separate identification and reporting of intraoperative radiation treatment (IORT) delivery and management; 77425 specifically describes a single IORT treatment session using electrons (for delivery using X-rays, see 77424). IORT delivers high-dose radiation precisely to a targeted area while shielding surrounding tissue.

IORT services include simulations but do not include E/M services beyond the treatment management session (77469).

Previously, this service would have been reported using 77470 (revised for 2012).

Radiation Treatment Management

● # 77469 Intraoperative radiation treatment management

AAPC Rationale
Code 77469 (and codes 77424 and 77425) has been added to allow separate identification and reporting of intraoperative radiation treatment (IORT) delivery and management. IORT delivers high-dose radiation precisely to a targeted area while shielding surrounding tissue.

Code 77469 specifically describes treatment management for IORT using either X-rays or electrons. E/M services beyond the treatment management are not included in 77469.
Radiation Treatment Management

- 77470 Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, or intraoperative cone irradiation, endocavitary irradiation)

AAPC Rationale
With the addition of 77424, 77425 and 77469 for separate identification and reporting of intraoperative radiation treatment (IORT), the descriptor for 77470 has been revised to eliminate the reference to intraoperative cone irradiation. You should no longer use 77470 to describe IORT.

Nuclear Medicine/Diagnostic/Gastrointestinal System

- 78220 Liver function study with hepatobiliary agents, with serial images

AAPC Rationale
Code 78220 has been deleted as obsolete.

Nuclear Medicine/Diagnostic/Gastrointestinal System

- 78223 Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function

AAPC Rationale
Code 78223 for hepatobiliary system imaging has been deleted and replaced by two new, more specific codes 78226 and 78227, below.

Nuclear Medicine/Diagnostic/Gastrointestinal System

- 78226 Hepatobiliary system imaging, including gallbladder when present;

AAPC Rationale
Code 78226 describes hepatobiliary system imaging only; for imaging with pharmacological stimulation of gallbladder and contraction, including quantification of gallbladder or hepatic function, see 78227.

Hepatobiliary system imaging evaluates the function of the liver, gall bladder, and the ducts that connect them.

Nuclear Medicine/Diagnostic/Gastrointestinal System

- 78227 Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed

AAPC Rationale
Code 78227 describes hepatobiliary system imaging with pharmacological stimulation of gallbladder and contraction, including quantification of gallbladder or hepatic function. For imaging only, see 78226.

Hepatobiliary system imaging evaluates the function of the liver, gall bladder, and the ducts that connect them.

Nuclear Medicine/Diagnostic/Respiratory System

- 78579 Pulmonary ventilation imaging (eg, aerosol or gas)

AAPC Rationale
Code 78579 has been added to report pulmonary ventilation imaging, which is used to see how well air moves through the lungs. The code may be applied whether the image is performed for aerosols or gases. Report 78579 only one time per imaging session.

For particulate perfusion imaging, see revised code 78580. For combined pulmonary ventilation and perfusion (aerosol or gas), see new code 78582.

Nuclear Medicine/Diagnostic/Respiratory System

- 78580 Pulmonary perfusion imaging (eg, particulate)

AAPC Rationale
Code 78580 has been revised to report pulmonary perfusion imaging with radioactive-labeled particles, which is used to measure the blood supply through the lungs. Report 78580 only one time per imaging session.

To report pulmonary ventilation imaging using an aerosol or gas, see new code 78579. For combined pulmonary ventilation (aerosol or gas) and perfusion, see new code 78582.
Nuclear Medicine/
Diagnostic/Respiratory System

● 78582 Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging

AAPC Rationale
New code 78582 has been added to report combined pulmonary ventilation (aerosol or gas) and perfusion, which together measure how well air and blood move through the lungs. Report 78582 only one time per imaging session.

For ventilation imaging only, see 78579. For perfusion imaging only, see 78580.

Nuclear Medicine/
Diagnostic/Respiratory System

78584 Pulmonary perfusion imaging, particulate, with ventilation, single breath

AAPC Rationale
Code 78584 has been deleted; see instead new codes 78579, 78582–78598.

Nuclear Medicine/
Diagnostic/Respiratory System

78585 Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single-breath

AAPC Rationale
Code 78585 has been deleted; see instead new codes 78579, 78582–78598.

Nuclear Medicine/
Diagnostic/Respiratory System

78586 Pulmonary ventilation imaging, aerosol; single-projection

AAPC Rationale
Code 78586 has been deleted; see instead new codes 78579, 78582–78598.

Nuclear Medicine/
Diagnostic/Respiratory System

78587 Pulmonary ventilation imaging, aerosol, multiple projections (eg, anterior, posterior, lateral views)

AAPC Rationale
Code 78587 has been deleted; see instead new codes 78579, 78582–78598.

Nuclear Medicine/
Diagnostic/Respiratory System

78588 Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, 1 or multiple projections

AAPC Rationale
Code 78588 has been deleted; see instead new codes 78579, 78582–78598.

Nuclear Medicine/
Diagnostic/Respiratory System

78589 Pulmonary ventilation imaging, gaseous, single-breath, single projection

AAPC Rationale
Code 78589 has been deleted; see instead new codes 78579, 78582–78598.

Nuclear Medicine/
Diagnostic/Respiratory System

78591 Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection

AAPC Rationale
Code 78591 has been deleted; see instead new codes 78579, 78582–78598.

Nuclear Medicine/
Diagnostic/Respiratory System

78593 Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection

AAPC Rationale
Code 78593 has been deleted; see instead new codes 78579, 78582–78598.

Nuclear Medicine/
Diagnostic/Respiratory System

78594 Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; multiple projections (eg, anterior, posterior, lateral views)

AAPC Rationale
Code 78594 has been deleted; see instead new codes 78579, 78582–78598.
Nuclear Medicine/
Diagnostic/Respiratory System
78596 Pulmonary quantitative differential function (ventilation/perfusion) study

AAPC Rationale
Code 78596 has been deleted; see instead new codes 78579, 78582–78598.

Nuclear Medicine/
Diagnostic/Respiratory System
- 78597 Quantitative differential pulmonary perfusion, including imaging when performed

AAPC Rationale
This procedure is intended to measure functional blood flow of the lungs. More specifically, it is a non-invasive (non-surgical) method of measuring the volume of lung receiving blood flow from the pulmonary arteries, and of providing a picture of how air is distributed.

The patient’s arm is injected with a radioactive tracer. If all is well, the scan will show an even distribution of radioactive material throughout both lungs. Areas of the lungs in which the radioactive material does not appear can indicate any number of conditions. Normally, it indicates a pulmonary embolism—a blocked artery or blood clot in the lung. It can also indicate the presence of a tumor or another lung disease, such as emphysema or pneumonia.

The perfusion scan is usually performed at the same time as a ventilation scan. A mask is placed over the patient’s face and he or she breathes a mixture of air and a mildly radioactive gas. The resulting images show which areas of the lungs may be receiving insufficient air during normal respiration.

Report 78598 only one time per imaging session.

Nuclear Medicine/
Diagnostic/Respiratory System
- 78598 Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed

AAPC Rationale
This procedure is intended to measure functional blood flow of the lungs. More specifically, it is a non-invasive (non-surgical) method of measuring the volume of lung receiving blood flow from the pulmonary arteries, and of providing a picture of how air is distributed.

The patient’s arm is injected with a radioactive tracer. If all is well, the scan will show an even distribution of radioactive material throughout both lungs. Areas of the lungs in which the radioactive material does not appear can indicate any number of conditions. Normally, it indicates a pulmonary embolism—a blocked artery or blood clot in the lung. It can also indicate the presence of a tumor or another lung disease, such as emphysema or pneumonia.

The perfusion scan is usually performed at the same time as a ventilation scan. A mask is placed over the patient’s face and he or she breathes a mixture of air and a mildly radioactive gas. The resulting images show which areas of the lungs may be receiving insufficient air during normal respiration.

Report 78598 only one time per imaging session.

Pathology and Laboratory
Molecular Pathology

AAPC Rationale
CPT® 2012 adds an entirely new subsection and 101 new codes (81200–81408) to the Pathology and Laboratory chapter to describe molecular pathology procedures. Molecular pathology is the study and diagnosis of disease through the examination of nucleic acid (including DNA and RNA). It is used to:

- Help to make rapid and accurate diagnoses.
- Detect and monitor infectious agents.
- Establish clonality (cells descended from and genetically identical to a single common ancestor), particularly for lymphoid diseases.
- Assess the presence of minimal residual disease for some malignancies following therapy.
- Determine prognosis and/or predict response to therapy.
- Perform testing for inherited diseases.

CPT® includes two full pages of instruction and definitions for proper application of molecular pathology codes, which are divided into Tier 1 (92 codes) and less-commonly-performed Tier 2 (9 codes) procedures. Individual codes are assigned according to the particular gene analyzed (eg, 81200 ASPA (aspartoacylase) gene analysis, common variants (eg, E285A, Y231X)). Molecular pathology codes include all analytical services (qualitative, unless otherwise noted) performed in the test: bundled services include cell lysis and nucleic acid stabilization. Procedures required prior to cell lysis (such as 88380 and 88381, microdissection) may be separately reported.

Coders needing to apply the molecular pathology services codes should consult their 2012 CPT® manual for complete
instructions and parenthetical guidelines, definitions, codes, and descriptors.

**Immunology**

- 86386 Nuclear Matrix Protein 22 (NMP22), qualitative

**AAPC Rationale**

Code 86386 has been added to report qualitative nuclear matrix protein 22 (NMP22) testing, for specific identification of the NMP22 protein. This test is valuable in the diagnosis of bladder cancer.

Previously, this service would have been reported using 86294 Immunassay for tumor antigen, qualitative or semiquantitative (eg, bladder tumor antigen).

**Immunology**

- ▲ 86703 Antibody; HIV-1 and HIV-2, single assay result

**AAPC Rationale**

To accommodate new code 87389 for HIV-1 antigen(s) with HIV-1 and HIV-2 antibodies (below), the descriptor for 86703 has been revised to specify “single result.” This test identifies only HIV antibodies.

When this test is performed using a kit or transportable instrument consisting of a single use, disposable analytical chamber, you should append modifier 92 Alternative laboratory platform testing to 86703.

**Microbiology**

- 87389 Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result

**AAPC Rationale**

New code 87389 has been added to describe HIV-1 antigen(s) with HIV-1 and HIV-2 antibodies, single result. This differs from those tests that identify antibodies only (eg, 86703).

When this test is performed using a kit or transportable instrument consisting of a single use, disposable analytical chamber, you should append modifier 92 Alternative laboratory platform testing to 87389.

**Cytopathology**

- 88107 Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears and simple filter preparation with interpretation

**AAPC Rationale**

Code 88107 has been deleted as obsolete. To report smears and simple filter preparation, see 88104 Cytopathology, fluids, washings or brushings; except cervical or vaginal; smears with interpretation and 88106 …simple filter method with interpretation.

**Cytopathology**

- ▲ 88312 Special stain including interpretation and report; Group I for microorganisms (eg, Gridley acid fast, methenamine silver), including interpretation and report, each

**AAPC Rationale**

Descriptors in the range 88312–88319 have been revised to better define special stains where procedures overlap two code definitions.

**Cytopathology**

- ▲ 88313 Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except immunocytochemistry and immunoperoxidase stain for microorganisms, stains for enzyme constituents, including interpretation or immunocytochemistry and report, each immunohistochemistry

**AAPC Rationale**

Descriptors in the range 88312–88319 have been revised to better define special stains where procedures overlap two code definitions.

**Cytopathology**

- ▲ +88314 Special stain including interpretation and report; histochemical staining with on frozen section(s) including interpretation and report tissue block (List separately in addition to code for primary procedure)

**AAPC Rationale**

Descriptors in the range 88312–88319 have been revised to better define special stains where procedures overlap two code definitions.
**Cytopathology**

88318 Determinative histochemistry to identify chemical components (e.g., copper, zinc)

**AAPC Rationale**

With the revision of 88312–88314 and 99319, code 88318 has been deleted as unnecessary. For determinative histochemistry to identify chemical components, see 88313.

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**Cytopathology**

▲ 88319 Special stain including interpretation and report; Group III, for enzyme constituents

**AAPC Rationale**

Descriptors in the range 88312–88319 have been revised to better define special stains where procedures overlap two code definitions.

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**Immunization**

**Administration for Vaccines-Toxoids**

▲ +90461 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)

**AAPC Rationale**

Descriptor language has been revised to mirror that of the primary code, 90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered.

A component is any vaccine antigen that prevents disease(s) caused by a single type of organism. You should report a single unit of 90460 for each vaccine administered; if a vaccine contains more than one component, you should report administration of additional components using add-on code 90461 ...each additional vaccine or toxoid component administered.

For example, an HPV vaccine includes a single component and would be coded as 90460, whereas a DTaP contains three components and would be reported 90460, 90461 x 2. Vaccine administration codes are reported in addition to vaccine and toxoid codes(s) 90476–90746.

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**Immunization**

**Administration for Vaccines-Toxoids**

90470 H1N1 Immunization administration (intramuscular, intranasal), including counseling when performed

**AAPC Rationale**

Code 90470 has been deleted; the H1N1 vaccine is no longer offered. The 2010–2011 flu season vaccine incorporates the H1N1 virus.

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**Vaccines, Toxoids**

▲ 90581 Anthrax vaccine, for subcutaneous or intramuscular use

**AAPC Rationale**

The term “or intramuscular” has been added to the descriptor to allow use of this code to describe either subcutaneous or intramuscular anthrax vaccine.
Vaccines, Toxoids

- 90644 Meningococcal conjugate vaccine, serogroups C & Y and hemophilus influenza B vaccine tetanus toxoid conjugate (Hib-MenCY-TT) (Hib-MenCY), 4 dose schedule, when administered to children 2–15 months of age, for intramuscular use

AAPC Rationale
Descriptor language has been updated to specify H. influenza type B (Hib) and N. meningitis serogroups C (MenC) and Y (MenY)-tetanus toxoid conjugate vaccine (Hib-MenCY). Note that this is a two-component (not three-component) vaccine. Code application does not change.

Vaccines, Toxoids

- 90654 Influenza virus vaccine, split virus, preservative-free, for intradermal use

AAPC Rationale
Code 90654 has been added to describe a lower antigen concentration than influenza vaccines intended for intramuscular delivery (90656, 90658); this influenza vaccine is preservative free and is administered using a prefilled, single-dose, disposable intra-dermal microinjection system. Code 90654 was accepted at the June 2010 CPT® Editorial Panel meeting for the 2012 CPT® book production cycle. The code was not included in the 2011 CPT® codebook; however, due to the Category I vaccine product codes early release policy, 90654 code was effective Jan. 1, 2011.

Vaccines, Toxoids

- 90663 Influenza virus vaccine, pandemic formulation, H1N1

AAPC Rationale
Code 90663 has been deleted; the H1NI vaccine is no longer offered. The 2010–2011 flu season vaccine incorporates the H1N1 virus.

Psychiatric Therapeutic Procedures/Other Psychiatric Services or Procedures

- 90867 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; planning initial, including cortical mapping, motor threshold determination, delivery and management

AAPC Rationale
The descriptor language has been revised to describe the content of the service as an initial TMS treatment, to include specifically cortical mapping, motor threshold determination, and the initial delivery and management. Subsequent delivery and management may be reported per session, using revised code 90868 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session.

TMS uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression, and it has been tested as a treatment tool for other neurological and psychiatric disorders including migraines, Parkinson’s disease, auditory hallucinations, and more.

Psychiatric Therapeutic Procedures/Other Psychiatric Services or Procedures

- 90868 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session

AAPC Rationale
The descriptor language has been revised to describe subsequent TMS delivery and management, per session. For initial TMS treatment (cortical mapping, motor threshold determination, and initial delivery and management), turn to 90867 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management.

TMS uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression, and it has been tested as a treatment tool for other neurological and psychiatric disorders including migraines, Parkinson’s disease, auditory hallucinations, and more.

Psychiatric Therapeutic Procedures/Other Psychiatric Services or Procedures

- 90869 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

AAPC Rationale
Code 90869 has been added to describe subsequent motor threshold re-determination with delivery and management for TMS, a procedure that uses magnetic fields to stimulate nerve cells in the brain and improve symptoms of depression. For initial motor threshold determination with delivery and management, see 90867 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management.
For subsequent delivery and management without motor threshold determination, see 90868 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session.

Gastroenterology

▲ 91010 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; 2-dimensional data

AAPC Rationale

The code descriptor has been revised to eliminate the reference to 2-dimensional data. These studies occur for evaluation of esophageal motility disorders such as achalasia or esophageal spasm. This procedure occurs without pressure topography.

To code stimulation or perfusion with motility study, report +91013 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure) in addition to 91010.

For high resolution esophageal motility studies, use 0240T Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with high resolution esophageal pressure topography study (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure).

Gastroenterology

▲ +91013 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion during 2-dimensional data study (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)

AAPC Rationale

The code descriptor has been revised to eliminate the reference to 2-dimensional data. These studies occur for evaluation of esophageal motility disorders such as achalasia or esophageal spasm. This procedure occurs without pressure topography.

To code stimulation or perfusion with motility study, report +91013 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure) in addition to 91010.

For high resolution esophageal motility studies, use 0240T Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with high resolution esophageal pressure topography study (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure).

Ophthalmology/Special Ophthalmological Services

92070 Fitting of contact lens for treatment of disease, including supply of lens

AAPC Rationale

Code 92070 has been replaced by new codes 92071–92072, which more precisely describe the disease for which contact lenses are fitted.

Ophthalmology/Special Ophthalmological Services

92071 Fitting of contact lens for management of keratoconus, initial fitting

AAPC Rationale

Code 92071, along with 92072 Fitting of contact lens for management of keratoconus, initial fitting, replaces deleted code 92070 for fitting of contact lens for treatment of disease; 92071 is specific to ocular surface disease. Supply of lens may be reported separately using 99070 Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided), or an appropriate HCPCS Level II supply code.

Do not report 92071 and 92072 together.

Ophthalmology/Special Ophthalmological Services

92072 Fitting of contact lens for management of keratoconus, initial fitting

AAPC Rationale
Code 92072, along with 92071 Fitting of contact lens for treatment of ocular surface disease, replaces deleted code 92070 for fitting of contact lens for treatment of disease; 92072 is specific to an initial fitting for management of keratoconus. Subsequent fittings may be reported using E/M service codes or general ophthalmological services codes.

Supply of lens may be reported separately using 99070 Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided), or an appropriate HCPCS Level II supply code.

Do not report 92072 and 92071 together.

**Special Otorhinolaryngologic Services/Audiologic Function Tests**

- **92558** Evoked distortion product evoked otoacoustic emissions; limited evaluation (single stimulus level to confirm the presence or absence of hearing disorder, either 2–6 frequencies) or transient of distortion produces) evoked otoacoustic emissions, with interpretation and report.

**AAPC Rationale**

Descriptor language for 92558 has been revised to clarify the intent of the code, which should be applied for the use of a limited number of frequencies to determine if the patient has experienced hearing loss.

- **92587** Evoked distortion product evoked otoacoustic emissions; limited evaluation (single stimulus level to confirm the presence or absence of hearing disorder, either 3–6 frequencies) or transient of distortion produces) evoked otoacoustic emissions, with interpretation and report.

**AAPC Rationale**

Descriptor language for 92587 has been revised to clarify the intent of the code, which should be applied for the use of a limited number of frequencies to determine if the patient has experienced hearing loss.

- **92588** Evoked distortion product evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparative quantitative analysis of transient and/or distortion product otoacoustic emissions at multiple levels and outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report.

**AAPC Rationale**

Descriptor language for 92588 has been revised to clarify the intent of the code, which should be applied for comprehensive—minimum of 12 frequencies—otoacoustic emissions testing (as opposed to limited testing, 92587).

- **92605** Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour.

**AAPC Rationale**

This service has been redefined to specify face-to-face interaction with the patient, and is now time based; report 92065 for the first hour and new code 92618 Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure) for each additional 30 minutes of face-to-face evaluation with the patient.

Augmentative and alternative communication devices are aids that allow individuals with severe speech impairment or absent speech to meet their functional communication needs.
Special Otorhinolaryngologic Services/Evaluative and Therapeutic Services

- # +92618 Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)

AAPC Rationale
Augmentative and alternative communication devices are aids to allow individuals with severe speech impairment or absent speech to meet their functional communication needs. Report revised code 92605 Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour for the first hour and add-on 92618 for each additional 30 minutes of face-to-face evaluation with the patient.

Cardiovascular/Injection Procedures

- 93561 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)

AAPC Rationale
A minor spelling revision does not change application of the code.

Indicator dilution studies are performed to measure cardiac output. The thermodilution technique uses a thermistor-tipped catheter (Swan-Ganz catheter) to measure temperature differences following injection of a cold saline solution into the blood. Using this data, a computer can calculate blood flow. The injection may be repeated several times and the cardiac output averaged. The indicator dilution technique is based on the principle that the volume of blood flow is related to the average dye concentration and the time taken for passage of the dye.

For subsequent cardiac output measurement, see 93562 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output.

Code 93561 includes cardiac catheterization, 93451–93462.

Cardiovascular/Noninvasive Vascular Diagnostic Studies/Noninvasive Physiologic Studies and Procedures

- 93720 Plethysmography, total body; with interpretation and report
AAPC Rationale

Code 93720 has been deleted and replaced by new code 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance.

Cardiovascular/Noninvasive Vascular Diagnostic Studies/Noninvasive Physiologic Studies and Procedures

93721 Plethysmography, total body; tracing only, without interpretation and report

AAPC Rationale

Code 93721 has been deleted and replaced by new code 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance.

Pulmonary/Other Procedures

94240 Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method thoracic gas volume

AAPC Rationale

Code 92420 has been deleted; to report thoracic gas volumes, see new codes 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance and 94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes.

Cardiovascular/Noninvasive Vascular Diagnostic Studies/Noninvasive Physiologic Studies and Procedures

93722 Plethysmography, total body; interpretation and report only

AAPC Rationale

Code 93722 has been deleted and replaced by new code 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance.

Pulmonary/Other Procedures

94240 Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method thoracic gas volume

AAPC Rationale

Code 92420 has been deleted; to report thoracic gas volumes, see new codes 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance and 94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes.

Cardiovascular/Cerebrovascular Arterial Studies

93875 Noninvasive physiologic studies of extracranial arteries, complete bilateral study (eg, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis)

AAPC Rationale

Code 93875 has been deleted; the service it describes is obsolete.

Cardiovascular/Other Noninvasive Vascular Diagnostic Studies

● 93998 Unlisted noninvasive vascular diagnostic study

AAPC Rationale

Code 93998 has been added as an “unlisted procedure” code to describe any noninvasive vascular diagnostic study not described by another, specific CPT® code.

Pulmonary/Other Procedures

94240 Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method thoracic gas volume

AAPC Rationale

Code 92420 has been deleted; to report thoracic gas volumes, see new codes 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance and 94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes.

Pulmonary/Other Procedures

94350 Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time

AAPC Rationale

Code 94350 has been deleted; see new codes 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance and 94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes.

Pulmonary/Other Procedures

94360 Determination of resistance to airflow, oscillatory or plethysmographic methods

AAPC Rationale

Code 94360 has been deleted; see new codes 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance and 94728 Airway resistance by impulse oscillometry.

Pulmonary/Other Procedures

94370 Determination of airway closing volume, single breath tests

AAPC Rationale

Code 94370 has been deleted; see new codes 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance and 94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes.
Pulmonary/Other Procedures

94720 Carbon monoxide diffusing capacity (eg, single-breath, steady state)

AAPC Rationale
Code 94720 has been deleted; see new add-on code +94729 Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure).

Pulmonary/Other Procedures

94725 Membrane diffusion capacity

AAPC Rationale
Code 94725 has been deleted; see new add-on code +94729 Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure).

Pulmonary/Other Procedures

- 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance

AAPC Rationale
New code 94726 (along with new codes 94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes and 94728 Airway resistance by impulse oscillometry) replaces deleted codes 94260, 94350, 94360, and 94370. Code 94726 specifically describes use of pulmonary plethysmograph to measure the functional residual capacity (FRC) of the lungs—the volume in the lungs when the muscles of respiration are relaxed—and total lung capacity.

Pulmonary/Other Procedures

- 94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes

AAPC Rationale
New code 94727 (along with new codes 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance and 94728 Airway resistance by impulse oscillometry) replaces deleted codes 94260, 94350, 94360, and 94370. Code 94727 specifically describes measurement of lung volumes by helium dilution or nitrogen washout, including determination of total lung capacity and all contributory lung volume determinations.

Pulmonary/Other Procedures

- 94728 Airway resistance by impulse oscillometry

AAPC Rationale
New code 94728 (along with new codes 94726 Plethysmography for determination of lung volumes and, when performed, airway resistance and 94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes) replaces deleted codes 94260, 94350, 94360, and 94370. Impulse oscillometry is complementary to spirometry in the early detection and follow up of pulmonary diseases such as asthma, chronic obstructive pulmonary disease (COPD) and idiopathic pulmonary fibrosis.

Pulmonary/Other Procedures

- +94729 Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure)

AAPC Rationale
Diffusion capacity is a measurement of the lung’s ability to transfer gases (ie, how efficiently the lungs take up oxygen), used to diagnose conditions such as emphysema or interstitial lung diseases.

Pulmonary/Other Procedures

- 94780 Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes

AAPC Rationale
Code 94780 (and 94781, below) describes the “car seat challenge.” Physiological monitoring studies indicate that some preterm infants experience episodes of oxygen desaturation, apnea, or bradycardia when seated in standard car safety seats. The American Academy of Pediatrics recommends that all preterm infants should be assessed for cardiorespiratory stability in their car seat prior to discharge.

Code 94780 is time based: Do not report 94780 for less than 60 minutes of testing. Rhythm ECG (93040–93042), non-invasive ear or pulse oximetry (94760, 94761), inpatient neonatal critical care (99468–99472), and initial hospital care, neonate (99477–99480) are included in 94780, and should not be reported separately.
Pulmonary/Other Procedures

- +94781 Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; each additional full 30 minutes (List separately in addition to code for primary procedure)

AAPC Rationale
Code 94781 is an add-on code to be reported only in addition to 94780 for each additional 30 minutes of car seat/bed testing for airway integrity, neonate, beyond the first hour. Do not report 94781 for less than 30 additional minutes. For example, for 80 minutes of testing, correct coding is 94780 only; for 110 minutes of testing, correct coding is 94780, 94781.

The American Academy of Pediatrics recommends that all preterm infants should be assessed for cardiorespiratory stability in their car seat prior to discharge.

Neurology and Neuromuscular Procedures/Electromyography

- # +95885 Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)

AAPC Rationale
Add-on codes 95885–95887 have been added to describe needle electromyography performed with nerve conduction, amplitude and latency/velocity study. Code 95885 applies per extremity and describes a limited study (eg, four or fewer muscles are tested per extremity), and should be reported in addition to a primary nerve conduction study code from the range 95900–95904.

Do not report 95885 in addition to 95905 Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report. Do not report 95885 with 95860–95864, 95870, or 95905, which describe similar EMG studies without with nerve conduction, amplitude, and latency/velocity study.

- # +95886 Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)

AAPC Rationale
Add-on codes 95885–95887 have been added to describe needle electromyography performed with nerve conduction, amplitude and latency/velocity study. Code 95886 applies per extremity and describes a complete study (eg, five or more muscles are tested per extremity), and should be reported in addition to a primary nerve conduction study code from the range 95900–95904.

Do not report 95886 in addition to 95905 Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report. Do not report 95885 with 95860–95864, 95870, or 95905, which describe similar EMG studies without with nerve conduction, amplitude, and latency/velocity study.

- # +95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)

AAPC Rationale
Add-on codes 95885–95887 have been added to describe needle electromyography performed with nerve conduction, amplitude and latency/velocity study. Code 95887 describes testing of non-extremities (eg, muscles supplied by the cranial nerve) and should be reported in addition to a primary nerve conduction study code from the range 95900–95904.

Do not report 95886 in addition to 95905 Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report. Do not report 95885 with 95867–95870, or 95905, which describe similar EMG studies without with nerve conduction, amplitude, and latency/velocity study.
Neurology and Neuromuscular Procedures/Electromyography

- # 95938 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs

AAPC Rationale
Code 95938 has been added to describe short latency somatosensory evoked potential studies of both the upper and lower limbs. In a sensory evoked potential the examiner stimulates a sense (touch), and the length of time for the electrical potential (or signal) to travel to the brain is measured. Such studies may be helpful to diagnose conditions such as brain death, coma, multiple sclerosis and other demyelinating diseases, spinal cord trauma, and more.

For study of the upper limbs only, report 95925 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs; for study of the lower limbs only, report 95926 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs.

Neurology and Neuromuscular Procedures/Electromyography

- # 95939 Central motor evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs

AAPC Rationale
Code 95939 has been added to describe central motor evoked potential study of both the upper and lower limbs. In a motor evoked potential, the examiner stimulates the brain and measures the response time to the muscles.

For study of the upper limbs only, report 95925 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs; for study of the lower limbs only, report 95926 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs.

Neurology and Neuromuscular Procedures/Electromyography

- # 95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

AAPC Rationale
Codes 95970—95975 have undergone minor descriptor revisions to clarify their use; the term “sacral” has been added to describe more precisely the nerves being tested.

Code 95970 describes subsequent electronic analysis of a previously implanted simple or complex brain, spinal cord, or peripheral neurostimulator pulse generator, without reprogramming. Such a system uses an implanted pulse generator and implanted electrodes to deliver low voltage electrical stimulation to targeted nerves, for instance for pain relief.

Neurology and Neuromuscular Procedures/Electromyography

- # 95971 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, autonomic sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

AAPC Rationale
Codes 95970—95975 have undergone minor descriptor revisions to clarify their use; the term “sacral” has been added to describe more precisely the nerves being tested.

Code 95971 describes either intraoperative (initial) or subsequent electronic analysis of a simple implanted spinal cord or peripheral neurostimulator pulse generator system, with programming. Simple programming includes changes to three or fewer of the following parameters: rate, pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, dose time, and more than one clinical feature (eg, rigidity, dyskinesia, tremor).
Neurology and Neuromuscular Procedures/Neurostimulators, Analysis-Programming

95972 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour

AAPC Rationale
Codes 95970—95975 have undergone minor descriptor revisions to clarify their use; the term "sacral" has been added to describe more precisely the nerves being tested.

Code 95972 describes either intraoperative (initial) or subsequent complex electronic analysis of an implanted spinal cord or peripheral (except cranial) neurostimulator pulse generator system, with programming. Complex analysis/programming includes changes four or more of the following parameters: rate, pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, dose time, and more than one clinical feature (eg, rigidity, dyskinesia, tremor).

Code 95972 is time-based, and should be reported once for the first documented hour of reprogramming time. For additional reprogramming beyond the first hour, see add-on 95973, below.

Neurology and Neuromuscular Procedures/Neurostimulators, Analysis-Programming

95973 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, autonomic nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

Code 95973 describes additional intraoperative (initial) or subsequent complex electronic analysis and programming, beyond the first hour, of an implanted spinal cord or peripheral (except cranial) neurostimulator pulse generator system. Complex programming includes changes four or more of the following parameters: rate, pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, dose time, and more than one clinical feature (eg, rigidity, dyskinesia, tremor).

Code 95973 is time-based, and should be reported with 95972 for each 30 minutes beyond the first hour of documented hour of reprogramming time.

Neurology and Neuromuscular Procedures/Neurostimulators, Analysis-Programming

95974 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour

AAPC Rationale
Codes 95970—95975 have undergone minor descriptor revisions to clarify their use.

Code 95974 describes either intraoperative (initial) or subsequent complex electronic analysis of a complex cranial nerve neurostimulator pulse generator/transmitter, with programming. Complex analysis/programming includes changes four or more of the following parameters: rate, pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, does time, and more than one clinical feature (eg, rigidity, dyskinesia, tremor).

Code 95974 is time-based, and should be reported once for the first documented hour of reprogramming time. For additional reprogramming beyond the first hour, see add-on 95975, below.
**Neurology and Neuromuscular Procedures/Neurostimulators, Analysis-Programming**

▲ +95975 Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

**AAPC Rationale**

Codes 95970→+95975 have undergone minor descriptor revisions to clarify their use.

Add-on code 95975 describes additional intraoperative (initial) or subsequent complex electronic analysis and programming, beyond the first hour, of a complex cranial nerve neurostimulator pulse generator/transmitter. Complex programming includes changes four or more of the following parameters: rate, pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, dose time, and more than one clinical feature (e.g., rigidity, dyskinesia, tremor).

Code 95975 is time-based, and should be reported with 95974 for each 30 minutes beyond the first hour of documented hour of reprogramming time.

**Neurology and Neuromuscular Procedures/Other Procedures**

▲ 95990 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed

**AAPC Rationale**

Code 95990 has been updated to specify that electronic analysis, when performed, is an included component of refilling and maintenance of implantable spinal or brain pump or reservoir for drug delivery. Implantable drug pumps are generally used for pain management and relief.

This code may be used only when the service requires a physician’s skill, and a physician provides the service. For services not requiring a physician’s skill or not performed by a physician, see 95990, above.

**Neurology and Neuromuscular Procedures/Central Nervous System Assessments-Tests (e.g., Neuro-Cognitive, Mental Status, Speech Testing)**

▲ 96110 Developmental testing screening, with interpretation and report, per standardized instrument form; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report

**AAPC Rationale**

Code language has been revised to provide clarity and to delete references to obsolete tests. Screening, as described by 96110, is subjective and based on observations recorded on a standard form. Developmental testing (96111), by contrast, is objective and requires that the child perform specific tasks of a standardized test.

**Neurology and Neuromuscular Procedures/Central Nervous System Assessments-Tests (e.g., Neuro-Cognitive, Mental Status, Speech Testing)**

▲ 96111 Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report
AAPC Rationale
Code language has been revised to provide clarity. Developmental testing is an objective, face-to-face assessment of a child’s skills that and requires the child to perform tasks associated with a standardized test. Screening as described by 96110, by contrast, relies on subjective observations of a child’s abilities.

Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration)

 AAPC Rationale
A sequential infusion is an infusion (or IV push) of a new substance or drug following a primary or initial service (eg, 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour). The descriptor for 96367 has been revised to specify the requirement for a new substance or drug.

Code 96367 is an add-on to be used only in addition to 96365, 96374 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug, 96409 Chemotherapy administration; intravenous, push technique, single or initial substance/drug, or 96413 Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug. Report a single unit of 96367 per sequential infusion of the same infusate mix.

CPT® guidelines allow facilities to report a sequential intravenous push of the same drug using 96376 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure).

Category II Codes
Category II codes are supplemental tracking codes that can be used for performance measurement under Medicare’s Physician Quality Reporting System (PQRS) or private payer pay-for-performance programs. Use of Category II codes is optional; they are not tied to a fee schedule and are intended for data collection regarding quality of care.

For 2012, CPT® has added 59 new Category II codes, revised five codes, deleted five codes, and reinstated two codes. For additional information, consult your CPT® manual or the AMA website at: http://www.ama-assn.org/go/cpt. You will find a dedicated link for Category II codes to the right of the screen, under the “Related Links” menu.

Category III Codes
Category III codes describe emerging technologies and, unlike Category I “unlisted procedure” codes, allow for tracking and collection of specific data. If a Category III code is available, it must be reported instead of a Category I unlisted procedure code. Category III codes have a five-year life span: Per CPT® guidelines, if a Category III code is not replaced by a Category I code (or otherwise revised) within five years, the Category III code will be archived “unless it is demonstrated that a temporary code is still needed.”

Category III Code

 AAPC Rationale
Code descriptor language has been revised to better specify the procedures that are intended as part of the service.

Category III Code

 AAPC Rationale
Code 0143T has been deleted for 2012. The AMA now recommends reporting pancreatic islet cell transplantation using Category I unlisted procedure code 48999 Unlisted procedure, pancreas.
Category III Code
0155T Laparoscopy, surgical; implantation or replacement of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)

AAPC Rationale
Codes 0155T and 0156T, below, have been deleted for 2012. The AMA now recommends reporting laparoscopic implantation, replacement, revision, or removal of gastric stimulation electrodes (lesser curvature) using Category I unlisted procedure code 43659 Unlisted laparoscopy procedure, stomach. For open procedures, see 43999 Unlisted procedure, stomach.

Category III Code
0156T Laparoscopy, surgical; revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)

AAPC Rationale
Codes 0156T and 0157T, above, have been deleted for 2012. The AMA now recommends reporting laparoscopic implantation, replacement, revision, or removal of gastric stimulation electrodes (lesser curvature) using Category I unlisted procedure code 43659 Unlisted laparoscopy procedure, stomach. For open procedures, see 43999 Unlisted procedure, stomach.

Category III Code
0157T Laparotomy, implantation or replacement of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)

AAPC Rationale
Codes 0157T and 0158T, below, have been deleted for 2012. The AMA now recommends reporting open implantation, replacement, revision, or removal of gastric stimulation electrodes (lesser curvature) using Category I unlisted procedure code 43999 Unlisted procedure, stomach. For laparoscopic procedures, see 43659 Unlisted laparoscopy procedure, stomach.

Category III Code
0158T Laparotomy, revision or removal of gastric stimulation electrodes, lesser curvature (ie, morbid obesity)

AAPC Rationale
Codes 0158T and 0157T, above, have been deleted for 2012. The AMA now recommends reporting open implantation, replacement, revision, or removal of gastric stimulation electrodes (lesser curvature) using Category I unlisted procedure code 43999 Unlisted procedure, stomach. For laparoscopic procedures, see 43659 Unlisted laparoscopy procedure, stomach.

Category III Code
0166T Transmyocardial transcatheter closure of ventricular septal defect, with implant; without cardiopulmonary bypass

AAPC Rationale
Codes 0166T and 0167T, below, have been deleted for 2012. The AMA now recommends reporting transmyocardial transcatheter closure of ventricular septal defect with implant (including cardiopulmonary bypass, when performed) using category I unlisted procedure code 33999 Unlisted procedure, cardiac surgery.

Category III Code
0167T Transmyocardial transcatheter closure of ventricular septal defect, with implant; with cardiopulmonary bypass

AAPC Rationale
Codes 0167T and 0166T, above, have been deleted for 2012. The AMA now recommends reporting transmyocardial transcatheter closure of ventricular septal defect with implant (including cardiopulmonary bypass, when performed) using category I unlisted procedure code 33999 Unlisted procedure, cardiac surgery.

Category III Code
0168T Rhinophototherapy, intranasal application of ultraviolet and visible light, bilateral

AAPC Rationale
Code 0168T has been deleted for 2012. The AMA now recommends reporting rhinophototherapy (intranasal application of ultraviolet and visible light) using category I unlisted procedure code 30999 Unlisted procedure, nose.

Category III Code
▲ 0240T Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with 3 dimensional high resolution esophageal pressure topography

AAPC Rationale
Category III code 0240T describes high-resolution esophageal motility studies. Like 91010 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report, high resolution esophageal pressure topography (HREPT) plots both time and pressure, but adds spatial locale and provides enhanced spatial resolution compared for evaluation of esophageal motility disorders.
such as achalasia or esophageal spasm. These procedures occur without pressure topography.

**Category III Code**

$\Delta$ +0241T Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion during 3-dimensional high resolution esophageal pressure topography study (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)

**AAPC Rationale**

Add-on Category III code 0241T describes high resolution esophageal motility studies with stimulation or perfusion. Like 91013 Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion during (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure), high resolution esophageal pressure topography (HREPT) plots both time and pressure, but adds spatial locale and provides enhanced spatial resolution for evaluation of esophageal motility disorders such as achalasia or esophageal spasm. These procedures occur without pressure topography.

**Category III Code**

$\bullet$ 0260T Total body systemic hypothermia, per day, in the neonate 28 days of age or younger

**AAPC Rationale**

Systemic hypothermia may be used to treat neonates exposed to hypoxia and ischemia at birth. Code 0260T describes total body hypothermia for neonates age 28 days or younger. Codes 0260T and 0261T were accepted at the June 2010 CPT® Editorial Panel meeting for the 2012 CPT® production cycle. Therefore, the codes did not appear in the 2011 CPT® codebook; however, due to the Category III code early release policy, these codes were effective Jan. 1, 2011.

**Category III Code**

$\bullet$ 0261T Selective head hypothermia, per day, in the neonate 28 days of age or younger

**AAPC Rationale**

Selective hypothermia may be used to treat neonates exposed to hypoxia and ischemia at birth. Code 0261T describes selective head hypothermia for neonates age 28 days or younger. Codes 0260T and 0261T were accepted at the June 2010 CPT® Editorial Panel meeting for the 2012 CPT® production cycle. Therefore, the codes did not appear in the 2011 CPT® codebook; however, due to the Category III code early release policy, these codes were effective Jan. 1, 2011.

**Category III Code**

$\bullet$ 0262T Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach

**AAPC Rationale**

Transcatheter heart valve replacement is a minimally invasive procedure in which a catheter is inserted using an endovascular approach to introduce an expandable pulmonary valve that is delivered to the diseased native valve. Code 0262T includes many related procedures, including all cardiac catheterizations, intraprocedural contrast injections, fluoroscopic radiological supervision and interpretation and imaging guidance necessary to complete the procedure.

**Category III Code**

$\bullet$ 0263T Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest

**AAPC Rationale**

Peripheral arterial disease (PAD) is a common circulatory problem in which narrowed arteries reduce blood flow, especially to the limbs. In patients affected by limb ischemia, local intramuscular autologous bone marrow cell therapy has shown encouraging results with consistent revascularization of affected limbs. Code 0263T describes the complete procedure, including both bone marrow cell therapy and bone marrow harvest. When reporting the complete procedure (0263T), do not separately report component services (0264T and 0265T).

Do not report 0263T with bone marrow or stem cell services/procedures 38204–38242; ultrasonic guidance for needle placement 76942; or duplex scan of lower extremity arteries or arterial bypass grafts 93925 and 93926.
**Category III Code**
- 0264T Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest

**AAPC Rationale**
Peripheral arterial disease (PAD) is a common circulatory problem in which narrowed arteries reduce blood flow, especially to the limbs. In patients affected by limb ischemia, local intramuscular autologous bone marrow cell therapy has shown encouraging results with consistent revascularization of affected limbs. Code 0264T describes bone marrow cell therapy only. Do not separately report this service with the complete procedure (0263T), which includes both bone marrow cell therapy and bone marrow harvest.

Do not report 0263T with bone marrow or stem cell services/procedures 38204–38242; ultrasonic guidance for needle placement 76942; or duplex scan of lower extremity arteries or arterial bypass grafts 93925 and 93926.

**Category III Code**
- 0265T Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy

**AAPC Rationale**
Peripheral arterial disease (PAD) is a common circulatory problem in which narrowed arteries reduce blood flow, especially to the limbs. In patients affected by limb ischemia, local intramuscular autologous bone marrow cell therapy has shown encouraging results with consistent revascularization of affected limbs. Code 0265T describes bone marrow harvest only. Do not separately report this service with the complete procedure (0263T), which includes both bone marrow cell therapy and bone marrow harvest.

Do not report 0263T with bone marrow or stem cell services/procedures 38204–38242.

**Category III Code**
- 0266T Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intraoperative interrogation, programming, and repositioning, when performed)

**AAPC Rationale**
The baroreflex or baroreceptor reflex is one of the body’s homeostatic mechanisms for maintaining blood pressure. Electrical activation of the carotid baroreflex has potential therapeutic value to control hypertension (high blood pressure).

Code 0266T describes implantation or replacement of a complete carotid sinus baroreflex activation device. For implantation or replacement of individual system components (lead or pulse generator), see 0267T and 0268T, below. For revision or removal, see 0269T–0271T. For device interrogation and programming only, see 0272T–0273T.

**Category III Code**
- 0267T Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intraoperative interrogation, programming, and repositioning, when performed)

**AAPC Rationale**
The baroreflex or baroreceptor reflex is one of the body’s homeostatic mechanisms for maintaining blood pressure. Electrical activation of the carotid baroreflex has potential therapeutic value to control hypertension (high blood pressure).

Code 0267T describes implantation or replacement of a carotid sinus baroreflex activation device lead, alone. Bilateral procedures may be reported with modifier 50 Bilateral procedure.

For implantation or replacement of a complete system, see 0267T, above. For implantation or replacement of pulse generator only, see 0268T, below. For revision or removal, see 0269T–0271T. For device interrogation and programming only, see 0272T–0273T.

Do not report 0267T in addition to 0266T or 0269T–0273T.

**Category III Code**
- 0268T Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intraoperative interrogation, programming, and repositioning, when performed)

**AAPC Rationale**
The baroreflex or baroreceptor reflex is one of the body’s homeostatic mechanisms for maintaining blood pressure.
Electrical activation of the carotid baroreflex has potential therapeutic value to control hypertension (high blood pressure).

Code 0268T describes implantation or replacement of a carotid sinus baroreflex activation device pulse generator, alone. For implantation or replacement of a complete system, see 0266T, above. For implantation or replacement of lead only, see 0267T, above. For revision or removal, see 0269T–0271T. For device interrogation and programming only, see 0272T–0273T.

Do not report 0268T in addition to 0266T or 0269T–0273T.

**Category III Code**

- 0269T Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)

**AAPC Rationale**
The baroreflex or baroreceptor reflex is one of the body’s homeostatic mechanisms for maintaining blood pressure. Electrical activation of the carotid baroreflex has potential therapeutic value to control hypertension (high blood pressure).

Code 0269T describes revision or removal of a complete carotid sinus baroreflex activation device. For revision or removal of individual system components (lead or pulse generator), see 0270T and 0271T, below. For implantation or replacement, see 0266T–0278T. For device interrogation and programming only, see 0272T–0273T.

Do not report 0269T with 0266T–0268T or 0270T–0273T.

**Category III Code**

- 0270T Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)

**AAPC Rationale**
The baroreflex or baroreceptor reflex is one of the body’s homeostatic mechanisms for maintaining blood pressure. Electrical activation of the carotid baroreflex has potential therapeutic value to control hypertension (high blood pressure).

Code 0270T describes revision or removal of a carotid sinus baroreflex activation device lead, alone. For bilateral removal, you may append modifier 50 Bilateral procedure.

For revision or removal of a complete system, see 0269T, above. For revision or removal of pulse generator only, see 0271T, below. For implantation or replacement, see 0266T–0278T. For device interrogation and programming only, see 0272T–0273T.

Do not report 0266T–0269T or 0271T–0273T in addition to 0270T.

**Category III Code**

- 0271T Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)

**AAPC Rationale**
The baroreflex or baroreceptor reflex is one of the body’s homeostatic mechanisms for maintaining blood pressure. Electrical activation of the carotid baroreflex has potential therapeutic value to control hypertension (high blood pressure).

Code 0271T describes revision or removal of a carotid sinus baroreflex activation device pulse generator. For revision or removal of a complete system, see 0269T, above. For revision or removal of lead only, see 0270T, above. For implantation or replacement, see 0266T–0278T. For device interrogation and programming, see 0272T–0273T.

Do not report 0271T with 0266T–0270T or 0272T–0273T.

**Category III Code**

- 0272T Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day)

**AAPC Rationale**
The baroreflex or baroreceptor reflex is one of the body’s homeostatic mechanisms for maintaining blood pressure. Electrical activation of the carotid baroreflex has potential thera-
peutic value to control hypertension (high blood pressure). Code 0272T describes in-person device interrogation only. Do not report 0272T with 0266T–0271T or 0273T.

**Category III Code**

- 0273T Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day; with programming

**AAPC Rationale**
The baroreflex or baroreceptor reflex is one of the body’s homeostatic mechanisms for maintaining blood pressure. Electrical activation of the carotid baroreflex has potential therapeutic value to control hypertension (high blood pressure). Code 0273T describes in-person device interrogation with programming.

Do not report 0273T with 0266T–0272T.

**Category III Code**

- 0274T Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic

**AAPC Rationale**
Spinal decompression procedures are performed to remove pressure from spinal nerves and relieve pain. Open laminotomy/laminectomy for decompression have been the standard, but less invasive techniques have been developed in recent years. Percutaneous laminotomy/laminectomy for spinal decompression is performed using a single 6 gauge portal site that involves a stab wound incision, resulting in less patient trauma and a quicker recovery. This method does not require fixation/stabilization devices or spacers, and can be conducted under a combination of local anesthetic and monitored anesthesia care (MAC), rather than general anesthesia. Code 0275T describes such a technique at single or multiple spinal levels, unilateral or bilateral, in lumbar region of the spine.

For similar technique of the cervical or thoracic spine, see 0274T, above. For open and endoscopically-assisted approach, see 63020–63035. For percutaneous decompression of the nucleus pulposus of intervertebral disc using need-based technique, see 62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous discectomy, percutaneous laser discectomy).

**Category III Code**

- 0275T Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar

**AAPC Rationale**
Spinal decompression procedures are performed to remove pressure from spinal nerves and relieve pain. Open laminotomy/laminectomy for decompression have been the standard, but less invasive techniques have been developed in recent years. Percutaneous laminotomy/laminectomy for spinal decompression is performed using a single 6 gauge portal site that involves a stab wound incision, resulting in less patient trauma and a quicker recovery. This method does not require fixation/stabilization devices or spacers, and can be conducted under a combination of local anesthetic and monitored anesthesia care (MAC), rather than general anesthesia. Code 0275T describes such a technique at single or multiple spinal levels, unilateral or bilateral, in lumbar region of the spine.

For similar technique of the cervical or thoracic spine, see 0274T, above. For open and endoscopically-assisted approach, see 63020–63035. For percutaneous decompression of the nucleus pulposus of intervertebral disc using need-based technique, see 62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous discectomy, percutaneous laser discectomy).

**Category III Code**

- 0276T Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe

For similar technique of the lumbar spine, see 0275T, below.
**AAPC Rationale**
Bronchial thermoplasty is a minimally-invasive, non-drug procedure for severe persistent asthma for patients whose asthma is not well-controlled with inhaled corticosteroids and long-acting beta-agonists. Thermal energy is delivered to the airway wall to reduce excessive airway smooth muscle (ASM). Reducing airway smooth muscle decreases the ability of the airways to constrict, thereby reducing the frequency of asthma attacks.

Code 0276T describes this procedure for a single lobe of the lung. Fluoroscopic guidance (when performed) and moderate sedation are included. For treatment of two or more lobes, see 0277T, below.

**Category III Code**
- ○ 0276T Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes

**AAPC Rationale**
Bronchial thermoplasty is a minimally-invasive, non-drug procedure for severe persistent asthma for patients whose asthma is not well-controlled with inhaled corticosteroids and long-acting beta-agonists. Thermal energy is delivered to the airway wall to reduce excessive airway smooth muscle (ASM). Reducing airway smooth muscle decreases the ability of the airways to constrict, thereby reducing the frequency of asthma attacks.

Code 0277T describes this procedure for two or more lobes of the lung. Fluoroscopic guidance (when performed) and moderate sedation are included. For treatment of a single lobe, see 0276T, above.

**Category III Code**
- ○ 0277T Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes

**Category III Code**
- 0278T Transcutaneous electrical modulation pain processing (eg, scrambler therapy), each treatment session (includes placement of electrodes)

**AAPC Rationale**
Code 0278T describes use of the Calmare® device for treatment of chemotherapy-induced peripheral neuropathy (CIPN) and other neuropathic pain. The therapy treats pain using a biophysical approach rather than through the use of drugs. Surface electrodes are applied to the skin. The device creates and sends a no-pain signal that becomes the dominant signal received by the brain, thus overriding the pain signal.

**Category III Code**
- 0279T Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood)

**AAPC Rationale**
Code 0279T describes circulation tumor cells (CTC) enumeration, to determine disease prognosis and treatment options in cancer patients. For interpretation and report, see 0280T.

**Category III Code**
- 0280T Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); interpretation and report

**AAPC Rationale**
Code 0280T describes interpretation and report of circulation tumor cells (CTC) enumeration, to determine disease prognosis and treatment options in cancer patients. Use with 0279T.

**Category III Code**
- 0281T Percutaneous transcatheter closure of the left atrial appendage with implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, radiological supervision and interpretation

**AAPC Rationale**
Code 0281T describes transcatheter placement of an implant to close the left atrial appendage, with the intent to deter formation of emboli. Do not report 0281T in addition to left heart catheterization (93462). CPT® provides additional instruction regarding which procedures may be reported separately.

**Category III Code**
- ○ 0282T Percutaneous or open implantation of neurostimulator electrode array(s), subcutaneous (peripheral subcutaneous field stimulation), including imaging guidance, when performed, cervical, thoracic or lumbar; for trial, including removal at the conclusion of

**AAPC Rationale**
Codes 0282T–0284T have been added to describe peripheral field stimulation to treat chronic cervical, thoracic, or lumbar pain. Unlike peripheral nerve stimulation, field
stimulation does not target a specific nerve; rather, electrode leads are placed in subcutaneous tissue to deliver electrical stimulation in a general area. Imaging guidance is included, when performed.

Code 0282T describes a trial placement.

**Category III Code**

- 0283T Percutaneous or open implantation of neurostimulator electrode array(s), subcutaneous (peripheral subcutaneous field stimulation), including imaging guidance, when performed, cervical, thoracic or lumbar; permanent, with implantation of a pulse generator

**AAPC Rationale**

Codes 0282T–0284T have been added to describe peripheral field stimulation to treat chronic cervical, thoracic, or lumbar pain. Unlike peripheral nerve stimulation, field stimulation does not target a specific nerve; rather, electrode leads are placed in subcutaneous tissue to deliver electrical stimulation in a general area. Imaging guidance is included, when performed.

Code 0283T describes a permanent placement.

**Category III Code**

- 0284T Revision or removal of pulse generator or electrodes, including imaging guidance, when performed, including addition of new electrodes, when performed

**AAPC Rationale**

Codes 0282T–0284T have been added to describe peripheral field stimulation to treat chronic cervical, thoracic, or lumbar pain. Unlike peripheral nerve stimulation, field stimulation does not target a specific nerve; rather, electrode leads are placed in subcutaneous tissue to deliver electrical stimulation in a general area. Imaging guidance is included, when performed.

Code 0284T describes revision/removal of pulse generator or electrodes, with placement of new electrodes, when performed.

**Category III Code**

- 0285T Electronic analysis of implanted peripheral subcutaneous field stimulation pulse generator, with reprogramming when performed

**AAPC Rationale**

Codes 0282T–0284T have been added to describe peripheral field stimulation to treat chronic cervical, thoracic, or lumbar pain. Unlike peripheral nerve stimulation, field stimulation does not target a specific nerve; rather, electrode leads are placed in subcutaneous tissue to deliver electrical stimulation in a general area. Imaging guidance is included, when performed.

Code 0285T describes analysis and reprogramming (when performed) of the pulse generator.

**Category III Code**

- 0286T Near-infrared spectroscopy studies of lower extremity wounds (eg, for oxyhemoglobin measurement)

**AAPC Rationale**

Near-infrared spectroscopy measures the percentage of hemoglobin oxygen saturation in the microcirculation of tissue up to 3 cm below the skin, and is potentially useful in assessing patients with peripheral arterial disease (PAD), acute compartment syndrome (ACS), and more. Code 0286T describes near-infrared spectroscopy studies of lower extremity wounds.

**Category III Code**

- 0287T Near-infrared guidance for vascular access requiring real-time digital visualization of subcutaneous vasculature for evaluation of potential access sites and vessel patency

**AAPC Rationale**

Near-infrared guidance is a technology that allows clinicians to more easily visualize blood vessels and gain venous access for those patients with difficult venous access (DVA). The technology uses near-infrared light, coupled with advanced technologies, to display an image of superficial vasculature directly onto a patient’s skin, which removes any doubt of locating a vessel for peripheral or central venous access.

Code 0287T describes this real-time digital projection of subcutaneous structures to locate hard-to-find vessels.

**Category III Code**

- 0288T Anoscopy, with delivery of thermal energy to the muscle of the anal canal (eg, for fecal incontinence)

**AAPC Rationale**

Code 0288T describes the delivery of radiofrequency energy to the muscles of the anal canal, resulting in a change in tissue compliance and a corresponding improvement in
incontinence symptoms. The procedure takes approximately one hour and is performed in an outpatient setting with the patient sedated.

Do not report 0288T with anoscopy procedures 46600–46615.

**Category III Code**

- +0289T Corneal incisions in the donor cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (List separately in addition to code for primary procedure)

**AAPC Rationale**

Keratoplasty, or cornea transplant, describes replacement of central corneal tissue damaged by eye disease or injury. Cornea transplants are routine, and are the most successful type of tissue transplants. Donor material must be obtained to perform the graft; add-on +0289T describes the use of a laser to prepare the donor cornea.

Report +0289T only with approved primary procedures 65710 Keratoplasty (corneal transplant); anterior lamellar, 65730 Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia), 65750 Keratoplasty (corneal transplant); penetrating (in aphakia), and 65755 Keratoplasty (corneal transplant); penetrating (in pseudophakia).

**Category III Code**

- +0290T Corneal incisions in the recipient cornea created using a laser, in preparation for penetrating or lamellar keratoplasty (List separately in addition to code for primary procedure)

**AAPC Rationale**

Keratoplasty, or cornea transplant, describes replacement of central corneal tissue damaged by eye disease or injury. Cornea transplants are routine, and are the most successful type of tissue transplants. Add-on +0290T describes graft preparation of the recipient cornea by laser incision.

Report +0290T only with approved primary procedures 65710 Keratoplasty (corneal transplant); anterior lamellar, 65730 Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia), 65750 Keratoplasty (corneal transplant); penetrating (in aphakia), and 65755 Keratoplasty (corneal transplant); penetrating (in pseudophakia).