1999 CPT Revisions

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This article will summarize some of the major additions and revisions in the *1999 Current Procedural Terminology* (CPT). A complete review of all the code and guideline changes -- including the rationale for these changes -- can be found in the November 1998 issue of the *CPT Assistant* newsletter. This monthly newsletter is published by the American Medical Association and is considered an official source for information on CPT. A complete summary of the additions, deletions, and revisions can also be found in Appendix B of the 1999 CPT.

Two new symbols have been added to the 1999 CPT. The first new symbol, +, identifies add-on codes. These add-on codes are also listed in a new appendix, Appendix E. The other new symbol, [circle with a backslash through it], is used to identify codes that are exempt from the use of modifier -51, but have not been designated as add-on procedures or services. These exempt codes are listed in the new Appendix F.

Another important change to note is that modifiers are no longer listed in the guidelines in front of each major section. Before the 1999 version, the common modifiers were listed in each section, but any modifier could be reported even if it was not listed for that section of CPT. To eliminate confusion and assist in reporting modifiers when they are needed to describe an altered circumstance or procedure, all modifiers can be found in Appendix A. It should also be noted that Appendix A includes a list of all modifiers applicable to 1999 CPT codes and a separate list of modifiers approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use. This is the first time some Level II (HCPCS/National) modifiers were listed in CPT.

New and Revised Codes

Evaluation and Management

A new code, 99298, was added in the neonatal intensive care section to report subsequent neonatal intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (less than 1500 grams). The purpose of this code is to differentiate very low birth weight neonates who are no longer critically ill, but continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring, and constant observation by the healthcare team under direct physician supervision. Neonates at this level of care would be expected to require infrequent changes in respiratory, cardiovascular, and/or fluid and electrolyte therapy as those induced under 99296 or 99297. This code would be reported once per day, on days subsequent to the admission date.

Integumentary System

Code 15000 was revised and code 15001 was added to further define the size of the surgical preparation or creation of recipient site for open wounds, burn eschar, or scar. Code 15000 is now used for the first 100 square centimeters (or one percent) of body area of infants and children and 15001 is used for each additional 100 square centimeters or each additional 1 percent of body area of infants and children. Note that 15001 is identified with a + and is considered an add-on code, therefore modifier -51 is not used.

Codes 15100-15121 for split skin grafts were significantly revised. Code 15100 is used to report a split graft for the trunk, arms, and legs for the first 100 square centimeters or less (or 1 percent) of body area of infants and children. Code 15101 is an add-on code indented under 15100 and is used to report each additional 100 square centimeters (or each additional 1 percent) of body area in infants and children for a split skin graft on the trunk, arms, legs. The CPT code description for 15120 and 15121 was revised to include hands and feet. Code 15121 is identified as an add-on code.

Codes 15350, 15351, 15400, and 15401 were revised to specify the size of the graft applied.

15350 *Application of allograft, skin; 100 square centimeters or less*

15351 *each additional 100 square centimeters (List separately in addition to code for primary procedure)*

15400 *Application of a xenograft, skin; 100 square centimeters or less*

15401 *each additional 100 square centimeters (List separately in addition to code for primary procedure)*

Codes 15936, 15946, and 15956 were changed. These descriptions no longer include the muscle or myocutaneous flap (as stated in 1998 CPT). The codes state "...in preparation for muscle or myocutaneous flap or skin graft closure." There is a reference after the codes to refer to codes 15734 and/or 15738 for repair of defect using muscle of myocutaneous flap in addition to the excision of ulcer code.

Musculoskeletal System

Many code descriptions were revised in this section to further clarify code meaning. Review all codes with a triangle in this section.

A new code was added to the femur and knee joint section, code 27347, excision of lesion of meniscus or capsule (e.g. cyst, ganglion), knee. Previously, there was no way of reporting this type of excision.

Respiratory System

Code 31090 was revised to further clarify that the sinusotomy should be unilateral on three or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid).

31090 *Sinusotomy, unilateral, three or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid)*

To distinguish between several different bronchoscopy procedures, one code was revised and several codes have been added. Code 31622 was revised to eliminate brushing. Code 31623 was added as an indented code for a bronchoscopy with brushing. Code 31624 was added as an indented code for bronchoscopy with bronchial alveolar lavage. An additional indented code, 31643 was added for placement of catheter(s) for intracavitary radioelement application. The intracavitary radioelement application would still be reported using codes 77761-77763 or 77781-77784.

A new code, 32001, was added for total lung lavage (unilateral). This procedure did not have a separate code previously.

Cardiovascular System

Code 35500 was added for harvesting one segment of an upper extremity vein for a lower extremity bypass procedure. The procedure would be listed separately in addition to the code for the primary procedure. This code will allow the physician to report the vein harvesting of a single vein segment from a separate incision and site.

A new subsection, "Composite Grafts," was added. This subsection includes both existing code 35681 and two new codes -- 35682 and 35683. Codes 35682-35683 are used to report harvest and anastomosis of multiple vein segments from distant sites for use as arterial bypass graft conduits. These codes should be used when two or more vein segments are harvested from a limb other than the one undergoing the bypass. These codes are designated as add-on codes and should be reported in addition to the bypass graft codes 35501-35587.

Two new codes were added and one code was revised for thrombectomy and revision of arteriovenous fistula. These changes clarify when a thrombectomy is performed alone, when a revision is performed alone, and when both a thrombectomy and a revision of the arteriovenous fistula are performed during the same operative session.

36831 *Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)*

36832 *Revision, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous, dialysis graft (separate procedure)*

36833 *with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)*

Digestive System

Code 45126 was added to the rectal section of CPT to describe pelvic exenteration for colorectal malignancy. This includes proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of tube(s) with or without removal of ovary(s), or any combination of these procedures.

Laparoscopy/Hysteroscopy

A new code was added to the laparoscopy section to identify a procedure that may be done laparoscopically. Code 56321 is an indented code describing a diagnostic laparoscopy with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal.

Female Genital System

A new series of codes were added to update current procedural techniques and code descriptions for vaginectomies. These new codes also differentiate between partial and complete vaginectomy. In order to accomplish this revision, code 57108 was deleted and codes 57106, 57107, 57109, 57111, and 57112 were added. Code 57110 was revised.

57106 *Vaginectomy, partial removal of vaginal wall;*

57107 *with removal of paravaginal tissue (radical vaginectomy)*

57109 *with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadentectomy and para-aortic lymph node sampling (biopsy)*

57110 *Vaginectomy, complete removal of vaginal wall;*

57111 *with removal of paravaginal tissue (radical vaginectomy)*

57112 *with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)*

Nervous System

Guidelines were added to the Neurostimulator (Spinal) subsection that specify the type of neurostimulator, what is included when coding these procedures, and how to code different approaches. Three codes -- 63650, 63655, and 63660 -- were revised to clarify how the procedure is performed.

Eye and Ocular Adnexa

Code 67027 was revised so that the description no longer includes replacement of intravitreal drug delivery system. To remove an intravitreal drug delivery system, refer to code 67121.

Codes 67208 and indented code 67210 were revised to further clarify the codes. A new code, 67220, was added for destruction of localized lesion of choroid, one or more session, photocoagulation (laser).

67208 *Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions; cryotherapy, diathermy*

67210 *photocoagulation*

The Strabismus surgery codes were significantly revised. Codes 67311-67318 can now be used regardless of previous eye surgery. These codes identify the number and type of muscle(s) operated on. Codes 67320-67332 were revised to clarify that these are add-on codes to explain the previous eye surgery or scarring that may complicate the current strabismus surgery. Codes 67334-67340 are now identified as add-on codes.

A new subsection was added to the surgery section for operating microscope. This new code, 69990, is an add-on code and should be listed in addition to the primary procedure when a surgical microscope is employed using the techniques of microsurgery. This code should not be used when the use of the operating microscope is an inclusive component of the procedure (as stated in the code description). It should be noted that this code replaces modifier -20, which was deleted in CPT 1999.

69990 *Use of operating microscope (List separately in addition to code for primary procedure)*

Medicine

The major change in the medicine section is how vaccine immunizations are reported. All vaccine immunizations will now be reported with a code for the product and a separate code for the administration of the vaccine.

Seventeen new codes, 90281-90399, were added solely to identify immune globulin product. These codes must be reported in addition to the appropriate administration method, 90780-90784. A new subsection with two new codes was added for immunization administration for vaccines/toxoids. Codes 90471 or 90472 must be reported in addition to the vaccine and toxoid code(s), 90476-90749.

A vaccines, toxoids subsection was added and includes 27 new vaccine codes, This new subsection, 90476-90748, identifies the vaccine product only and must be reported in addition to the immunization administration codes 90471 or 90472. The rest of the vaccine codes were modified to delete the administration and further clarify the actual vaccine.

Two new codes were added in the cardiac catheterization subsection for intravascular doppler velocity. These codes are used during coronary angiography including pharmacologically induced stress.

93571 *Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (list separately in addition to code for primary procedure)*

I93572 *each additional vessel (list separately in addition to code for primary procedure)*

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