2009 CPT Coding Update

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Changes to CPT codes for 2009 include 293 additions, 133 revisions, and 92 deletions. This article highlights some of the more notable changes; a comprehensive list can be found in appendix B of the 2009 CPT code manual. The changes took effect January 1.

E/M Codes

Numerous changes were made to the pediatric E/M codes including newborn care services, delivery and birthing room attendance and resuscitation services, pediatric critical care patient transport, and inpatient neonatal and pediatric critical care services. Coding professionals should read the extensive revisions to the instructional notes as many codes were renumbered for 2009.

A new section titled “Newborn Care Services” was added to report the physician services provided to newborns in a variety of settings from birth through the first 28 days of life. These services are reported using codes 99460–99463, replacing deleted codes 99431–99435. They include the maternal and fetal history, newborn history and physical examination, ordering of diagnostic tests and treatments, discussions with the family, and documentation in the patient’s health record.

Codes 99464 and 99465 were added to report delivery and birthing room attendance and resuscitation services, replacing deleted codes 99436–99440. There is an error in the code book under the parenthetical note for code 99465. The note should read that code 99465 *may be* reported in conjunction with codes 99460, 99468, and 99477.

Codes 99466 and 99467 were added to report direct face-to-face physician services provided during the interfacility transport of a critically ill or critically injured pediatric patient who is 24 months of age or less. These are time-based codes.

In addition, codes for inpatient and pediatric critical care (99468–99476) were added and are distinguished between initial and subsequent critical care based on the age of the child. These codes may only be reported by a single provider once per patient/per day. Initial and continuing intensive care services are reported using codes 99477–99490. These are services provided to a child who is not a normal newborn (e.g., low birth weight) but who requires intensive observation, frequent interventions, and other intensive care services.

It should be noted that additional instructions were added under the critical care services codes (99291 and 99292) as a result of the extensive changes made to the pediatric and neonatal critical care services.

Another notable change in the E/M section is under the prolonged physician service codes with direct patient contact (99354–99357). The instructions were revised to clarify that these time-based add-on codes may be reported in addition to the primary E/M service (at any level), which has a typical or specified time published in the CPT code book. As a result of this clarification, modifier 21, prolonged evaluation and management services, was deleted.

Surgery

Integumentary System

The intermediate repair codes 12031–12057 were revised to eliminate the confusion caused by the definition of intermediate repair and the lack of this term appearing in the actual code descriptor. These codes now include the term “intermediate” in the code descriptors for this series.

Musculoskeletal System

Codes 20696 and 20697 were added to describe the application of multiplane, unilateral, external fixation with stereotactic computer-assisted adjustment. These codes may not be reported in conjunction with 20692 or in combination with each other.

While no new codes have been added to the spinal instrumentation codes, parenthetical notes were revised for add-on codes 22840–22848 and 22851 to delete the reference to code 22208. This code was incorrectly included in the parenthetical notes in 2008 and should not be reported in addition to the codes in this series.

Three new codes (22856, 22861, and 22864) were added to report artificial cervical total disc arthroplasty, replacing category III codes 0090T, 0096T, and 0093T. These codes describe the entire procedure and no longer require component coding. Coders should review the parenthetical notes for additional reporting instructions.

Codes 27027 and 27057 were added to report decompression fasciotomies. These represent unilateral procedures; therefore, modifier 50 should be appended if these procedures are performed bilaterally. The debridement codes (11040–11043) should not be reported in addition to code 27057 as it is an inclusive component of the procedure.

Cardiovascular System

Codes 35535 and 35570 were added under vein bypass graft to report creation of bypass grafts for revascularization of the right kidney and the lower extremity. Three new codes were added for prosthetic bypass grafts with other than vein and include ilio-celiac (35632), iliomesenteric (35633), and iliorenal (35634).

Digestive System

Two new codes were added to report procedures used to treat snoring and obstructive sleep apnea. Code 41512 is used to report tongue base suspension by permanent suture technique, and code 41530 is used to report submucosal ablation of the tongue base, which replaces category III code 0088T.

A new add-on code, 43273, for endoscopic cannulation of the papilla with direct visualization of the common bile duct and/or pancreatic duct was added. This code is intended to be reported separately in addition to the code for the primary procedure (43260, 43261, 43263–43265, and 43267–43272).

Another significant change to the digestive system codes is the addition of code 46930, Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency). Coders should review the parenthetical note under this code for important reporting instructions regarding the different methods of removal and destruction of hemorrhoids.

Several new hernia repair codes were added for laparoscopic and surgical hernia repair (49652–49657). These codes include mesh insertion when performed. The language in the code descriptor for add-on code 49568 was revised to include the word “open.” It is not appropriate to report code 49568 with this series of codes.

Nervous System

Several significant changes were made to codes for reporting stereotactic radiosurgery. As a result of changes in technology, code 61793 was deleted and codes 61796–61800 (cranial) and 63620–63621 (spinal) were added. Instructions added for 2009 outline important reporting guidelines.

New code 62267 describes percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes. When imaging guidance is performed, codes 77003 and 77012 are separately reportable in addition to code 62267.

Eye and Ocular Adnexa

Code 65756 was added to report endothelial keratoplasty. In addition, add-on code 65757 was created to report the transplant preparation in conjunction with the endothelial keratoplasty code when the surgeon prepares the graft at the time of implant.

Radiology

There are relatively few changes to the radiology section for 2009. Three new codes (77785–77787) were added for remote afterloading high-dose rate radionuclide brachytherapy based on the number of channels. Codes 77781–77784 have been deleted.Code 78808 was added to report an injection procedure for radiopharmaceutical localization by nonimaging probe study.

Pathology and Laboratory

Several codes were revised under molecular diagnostics to clarify the reporting of codes 83890–83909. New guidelines were added to this section regarding nucleic acid preparation. In addition, a new subsection for in vivo (e.g., transcutaneous) laboratory procedures has been added along with three new codes (88720–88741).

Medicine End-Stage Renal Disease Services

Codes 90951–90962 are reported once per month to differentiate services based on age related to the patient's end-stage renal disease (ESRD) performed in an outpatient setting. There are three levels of service based on the number of face-to-face visits. These codes are intended to report the physician-related services and do not include the dialysis procedure. Physician services include establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls, and patient management during the dialysis provided during a full month.

For ESRD and non-ESRD dialysis services performed in an inpatient setting and for non-ESRD dialysis services performed in an outpatient setting, see codes 90935–90937 and 90945–90947. Codes 90963–90966 are used to report ESRD-related services for home dialysis patients per full month. Codes 90967–90970 should be reported for ESRD services less than a full month.

Cardiovascular

Cardiography

Codes 93228 and 93229 were added to describe wearable mobile cardiovascular telemetry. These codes should not be reported if the device is worn fewer than 10 days. Errata regarding these codes are available on the AMA Web site at www.ama-assn.org/ama/pub/category/13282.html. Additional guidelines have been added to this section to describe attended surveillance and mobile cardiovascular telemetry.

Fifteen codes in this section were revised; therefore, coders who report these services should study this section carefully.

Cardiovascular Device Monitoring—Implantable and Wearable Devices

The most extensive changes in the medicine section were made to this section. Twenty-one codes (93279–93299) and several pages of new guidelines were added for 2009.

Echocardiography

Code 93306 was added, and codes 93307 and 93308 were revised. New guidelines offer instructions for reporting a complete transthoracic echocardiogram and stress echocardiography.

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

Codes 90760–90779 were deleted and renumbered to 96360–96379 to allow a clearer comparison of infusion services procedures. This reorganization includes revision of the subheadings and brings this series of codes in closer proximity to the chemotherapy and other highly complex drug or highly complex biologic agent administration codes 96401–96549.

The guidelines pertaining to the entire set of infusion codes were relocated and revised.

Category II Codes

While the use of category II codes is optional, it is the fastest growing section of the code book. In 2009, 143 new codes were added for quality improvement measures. In addition, there are 12 new clinical conditions and 14 revised clinical conditions. Appendix H cross-references the measure associated with each code.

Category III Codes

Thirteen new category III codes have been added, and 22 codes have been deleted. Among the new codes are 0188T and add-on 0189T for remote real-time interactive videoconferenced critical care services.

Modifiers

The most notable change to the modifiers is the deletion of modifier 21. Codes 99354–99357 should be used to report prolonged physician services. Coders should review the guidelines in the E/M section regarding reporting these codes.

References

American Medical Association (AMA). *CPT 2009 Changes: An Insider's View.* Chicago, IL: AMA, 2008.

AMA. *Current Procedural Terminology (CPT) 2009.* Chicago, IL: AMA, 2008.

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