CPT Changes for 2001

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CPT 2001 Professional Edition (CPT® 2001) is complete and should be landing on your desk soon. As an introduction to the new book, this article provides a brief summary of the changes in 2001. A complete listing of the code and guideline changes can be found in CPT Changes 2001: An Insider's View, which explains every new, revised, and deleted code along with a detailed rationale for the change. 1 A complete listing of additions, deletions, and revisions may also be found in Appendix B of the 2001 CPT book.

The total number of codes for CPT 2001 is 7,928, up from 7,755 in CPT 2000. All of the major sections of CPT 2001, including Appendices A, B, C, E, and F, have undergone change.

Where to Expect Changes

The greatest number of code changes appears in the Pathology and Laboratory section. Of these, the Microbiology subsection contains most of the code additions, deletions, and revisions. Other changes to notes, headings, and cross references have been made to reflect current technology and clinical practice.

The Surgery section experienced the second-greatest number of changes. The Integumentary, Cardiovascular, Digestive, and Male Genital system subsections now include procedures involving the latest surgical techniques. New related illustrations appear in the CPT 2001 professional edition. In addition, throughout the Surgery section, more than 100 other changes have been made to important cross references, notes, headings, and other explanatory text.

As with other major sections of CPT 2001, the Medicine section includes code additions, revisions, and one code deletion as well as the addition of various headings, cross references, and explanatory text. Important changes have been made to the Immunization, Cardiovascular, Dialysis, and Physical Medicine and Rehabilitation subsections.

Other changes to CPT 2001 include the addition of modifiers -27 and -60, revision of modifier -22 and more than 10 new illustrations related to the new codes.

The appendices were also changed. Appendix A includes two new modifiers and a correlating revision to an existing modifier. Appendices B, C, E, and F have been updated to correlate with the 408 code changes for CPT 2001.

The symbols denoting new and revised codes throughout the CPT book will help to familiarize you with the changes. For a complete listing of these symbols, refer to the Code Changes section in the introduction to the book.

Additions and Revisions

Evaluation and Management

The term "professional services" has been defined in relation to the new and established patient definitions in the Evaluation and Management (E/M) section. The new explanatory text defines professional services as "those face-to-face services rendered by a physician and reported by a specific CPT code(s)." Other changes include the Critical Care Introductory notes, which have been revised to clarify reporting of critical care when provided to a critically ill, injured, or post-operative patient. These revisions should be helpful in deciding when to report the critical care codes as opposed to the emergency department services and other E/M codes. In addition, the Care Plan Oversight notes and codes have been revised. Codes 99374, 99377, and 99379 now reflect an expanded range of settings as well as addressing the full scope of providers associated with these services.

Anesthesia

Revisions continue to be made to the Anesthesia section to reflect current anesthesia practice. Thirteen codes were revised and 10 codes were added. Three cross references were also added to correlate with the two deleted codes and the use of a new add-on code.

Integumentary

The Introductory notes of the Excision of Benign and Malignant Lesions were revised to clarify that an Intermediate or Complex closure should be reported separately when performed in addition to the excision of a benign or malignant lesion. To coincide with this revision, the definition of complex repair was also revised, indicating that complex repair does not include excision of benign or malignant lesions.

Two new codes were added for the application of tissue-cultured skin grafts including bilaminate skin substitutes/neodermis. The Free Skin Graft Introductory notes also were revised to clarify reporting of tissue-cultured skin grafts.

The series of breast biopsy codes were revised to differentiate the reporting of open versus percutaneous breast biopsy procedures as well as those that use imaging guidance. The following new codes were added as indents under parent code 19100:

19102 Percutaneous, needle core, using imaging guidance
19103 Percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

In order to differentiate between new codes 19102 and 19103, codes 19100 and 19101 were revised. Code 19100 now specifies "not using imaging guidance" as opposed to new code 19102 that includes imaging guidance. The descriptors of codes 19101, 19120, and 19125 were revised to specify "open." Code 19126 was revised to clarify reporting of a lesion identified by a "preoperative" radiological marker. And code 19295 was included as an add-on code to identify percutaneous image-guided placement of a metallic localization clip during breast biopsy. The cross reference added after new code 19295 instructs that code 19295 should be reported in addition to code 19102.

Musculoskeletal

Few changes were made in the Musculoskeletal section for 2001. The major changes include revisions to the Spine Introductory notes and the addition of three new codes for percutaneous vertebroplasty. The Spine Introductory notes were revised to include further detail of the use of modifier -62 with spine surgery procedures. A new subsection and the following codes were added describing percutaneous vertebroplasty procedures:

22520 Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic
22521 lumbar
22522 each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

Two new radiology codes, 76012 and 76013, have also been added for the radiologic supervision and interpretation of percutaneous vertebroplasty procedures.

Cardiovascular System

A new subsection and 12 new codes were added to describe placement of an endovascular graft for abdominal aortic aneurysm repair. The procedures described by new codes 34800-34826 involve less invasive techniques for repairing the aneurysm. The introductory notes to this new subsection clearly state the procedures included in performing the aneurysm repair and guide the user to the radiology section when appropriate. Many of the codes are followed by multiple cross references detailing appropriate use of the codes.

Code 35600 was added for harvesting an upper extremity artery for coronary artery bypass procedures. The Combined Arterial-Venous and Arterial Grafting for Coronary Artery Bypass Introductory notes also were revised, reflecting the addition of new code 35600. As indicated in the notes, procurement of an artery for grafting is included in codes 33533-33536 and should not be reported as separate except when an upper extremity artery (new code 35600) is procured.

Other changes to the cardiovascular system section include the addition of a new code for collection of a blood specimen from a partially or completely implantable venous access device, and a new code for percutaneous thrombectomy of an arteriovenous fistula, autogenous or nonautogenous graft.

Hemic and Lymphatic Systems

Codes 38500 and 38510-38530 were revised by the addition of the term "open" to the descriptors. The separate procedure designation was removed from codes 38500 and 38530 to clarify reporting of sentinel lymph node biopsy and excision procedures. Because sentinel node biopsy procedures require reporting code 38792 for the injection procedure for identification of the sentinel node and the appropriate biopsy/excision procedure code from the 38500-38530 series, removal of the separate procedure designation was necessary to ensure the reporting of both codes in sentinel node biopsy procedures.

Digestive System

Within the Digestive System series of codes, 14 new endoscopy codes were added and one endoscopy code revised. The additions were necessary to describe current transmural and transendoscopic procedures, endoscopic stenting procedures, and endoscopic and transendoscopic ultrasound-guided procedures. Four codes were added describing small bowel transplantation procedures involving cadaver or living donors. Laparoscopic procedures 49320 and 49321 were revised to distinguish between diagnostic and surgical procedures. In addition, the following code was added to the Stomach subsection:

43752 Naso- or oro-gastric tube placement, necessitating physician's skill

Urinary System

The major changes in the urinary section involve the laparoscopic codes and cystourethroscopic codes. Four new laparoscopic codes were added for radical nephrectomy, ureteroneocystostomy, and unlisted ureter procedures. To accommodate these procedures, codes 50546 and 50548 were revised and a grammatical change was made to 50945.

Cystourethroscopic codes 52335, 52336, 52337, 52338, 52339, and 52340 were renumbered and relocated as 52351, 52352, 52353, 52354, 52355, and 52400. The code descriptors remained the same for all codes except new code 52351 (formerly code 52335), with the addition of the term "diagnostic" and deletion of the parenthetic descriptor "(includes dilation of the ureter and/or pyeloureteral junction by any method)." The revision of code 52351 was necessary to differentiate it from the new therapeutic ureteral dilation codes 52341-52346. These six new codes (52341 to 52346) were added to the ureter and pelvis section to describe endoscopic treatment of non-calculus strictures in the ureter, ureteropelvic junction, and intra-renal areas.

Nervous System

Codes 61697 and 61698 were added and 61700 and 61702 were revised to differentiate between surgery of simple and complex carotid circulation and vertebrobasilar circulation aneurysms. Other major changes in this section include the revision of code 63040 and the addition of codes 63043 and 63044. Code 63040 was revised to state "single interspace" and 63043 and 63044 were added as "each additional interspace" codes to clarify that this series of codes is reported per interspace, as opposed to an entire region of the spine (for example, lumbar). In addition, cross references have been added for clarifying that these codes are unilateral.

New code 64614 was added for Chemodenervation of muscles of the limb and trunk to treat, for example, dystonia, cerebral palsy, and multiple sclerosis. Code 64612 and the heading for the 64600-64680 series of codes were revised by deleting the phrase "destruction by neurolytic agent" because the term "destruction" was not accurate as the nerve is chemodenervated and not destroyed.

Radiology

Seven new codes were added for computed tomography angiography (CTA), which is used for imaging vessels. These codes describe CTA procedures of the head, neck, chest, pelvis, upper extremity, lower extremity, abdomen, abdominal aorta, and bilateral iliofemoral lower extremity. The magnetic resonance imaging (MRI) codes have also been expanded, with the revision of nine codes and the addition of 16 new codes. The majority of MRI changes involve adding codes that describe the use of contrast material when performing the MRI. To describe distinct anatomic areas and the use of contrast materials, one magnetic resonance angiography (MRA) code was deleted and six new codes added.

To allow for greater flexibility in reporting radiologic examination codes and minimize the use of the unlisted radiology codes, several descriptors for the spine, pelvis, and extremity examination codes were revised. These revisions involve specifying the number of views versus the types of views performed. For example, code 72040 was revised with the deletion of "anteroposterior and lateral," which was replaced with "two or three views." Other changes to radiology include fetal biophysical profile codes with an editorial revision of code 76818 and the addition of code 76819 as follows:

76818 Fetal biophysical profile; with non-stress testing
76819 without stress or non-stress testing

Pathology and Laboratory

As previously stated, the Pathology and Laboratory section included the greatest amount of changes. This section includes comprehensive revisions that update codes for drug testing, therapeutic drug assays, urinalysis, chemistry, hematology and coagulation, immunology, microbiology, cytopathology, and surgical pathology, as well as other procedures. These changes were made to reflect current clinical practice and provide consistency and clarification throughout the section.

The microbiology section included significant revisions to reflect modern technology advances and current practice. Many revisions were made to incorporate preferred terminology and clarify abbreviations and use of codes. For example, references to "commercial kit" have been deleted. Specimen type is now sequenced in the code descriptors to maintain a standard throughout the section. Overall, there were 41 revisions, 32 new codes, and 16 deleted codes in the Microbiology section.

A new subsection entitled Transcutaneous Procedures was also added to the Pathology and Laboratory section with the addition of the following code for the detection of hyperbilirubinemia using transcutaneous bilirubinometers:

88400 Bilirubin, total, transcutaneous

Medicine

Changes to the Medicine section occurred in several areas, including cardiovascular, dialysis, gastroenterology, otorhinolaryngologic services, neurology, physical medicine and rehabilitation, medical nutrition therapy, and vaccines.

The Physical Medicine and Rehabilitation section includes a new heading and two new codes for Active Wound Care Management. New codes 97601 and 97602 are intended to be reported for active wound care as performed by physical therapists, occupational therapists, and enterostomal nurses. For wound debridement by physicians, codes 11040 to 11044 should be reported.

Codes 97532 and 97533 were added to describe Cognitive Skills Development and Sensory Integrative Techniques previously reported with code 97770. Deleted code 97770 was split into the two new codes to eliminate confusion in reporting these services.

A new subsection and three new codes were added to describe Medical Nutrition Therapy. Codes 97802, 97803, and 97804 are time-based codes used for medical nutrition therapy assessment and reassessment of individuals and in a group.

Code 99172 was added to describe a visual function screening meeting requirements by federal agencies and civilian/professional organizations to assess the visual functions of workers in industrial, transportation, and civilian jobs.

Modifiers

Two new modifiers were added to CPT 2001: -27 and -60. As a result of the addition of modifier -60, modifier -22 was revised with the addition of a Note at the end of the modifier descriptor.

-22 Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier -22 to the usual procedure number or by use of the separate five digit modifier code 09922. A report may also be appropriate. Note: This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior surgery, irradiation, infection, very low weight (as in neonates and infants less than 10 kg) or trauma. (See modifier -60, as appropriate.)

-27 Multiple Outpatient Hospital E/M Encounters on the Same Date: For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier -27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving E/M services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (for example, a hospital emergency department and clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient E/M services provided by the same physician on the same date and performed in multiple outpatient setting(s) such as in a hospital emergency department and clinic, see E/M, Emergency Department, or Preventive Medicine services codes.

-60 Altered Surgical Field: Certain procedures involve significantly increased operative complexity and/or time in a significantly altered surgical field resulting from the effects of prior surgery, marked scarring, adhesions, inflammation, or distorted anatomy, irradiation, infection, very low weight (as in neonates and small infants less than 10 kg) and/or trauma (as documented in the patient's medical record). These circumstances should be reported by adding modifier -60 to the procedure number or by use of the separate five-digit modifier code 09960. Note: For unusual procedural services not involving an altered surgical field due to the effects of previous surgery, irradiation, infection, very low weight and/or trauma, append modifier -22 or use the separate five-digit code 09922.

Note

1. American Medical Association. *CPT Changes 2001: An Insider's View*. Chicago, IL: American Medical Association, 2000.

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