CPT Code Updates for 2012

By Karen O'Hara, BS, CCS-P

The 2012 updates to the CPT code set include 278 new codes, 139 code revisions, and 98 code deletions. This brings the total number of CPT codes to 9,641.

All major sections of the CPT code set, as well as the introduction and appendix A, have undergone changes. Beginning with the introduction to the code set, the "Instructions for Use of the CPT Codebook" were revised to include the CPT definition of qualified healthcare professionals, distinguishing them from clinical staff members.

All changes are effective January 1 of this year.

This article offers a summary of the updates, highlighting notable changes for 2012. The complete list of changes is found in appendix B of the code set.

Evaluation and Management

The evaluation and management (E/M) section includes revisions to the definitions of new and established patients. The definitions now include reference to physicians of the same specialty and subspecialty when determining a new or established patient within a group practice.

The revised definitions state that the physician or another physician from the same group practice must be from the exact same specialty and subspecialty. To illustrate this definition, a revised "Decision Tree for New and Established Patients" was reinstated in 2012.

Other E/M changes include revisions to the prolonged services subsection, including:

- Removing the reference to "physician" and "face-to-face" from the title
- Adding "other qualified healthcare professional" to the guidelines
- Defining direct patient care
- Adding observation as a setting for the inpatient prolonged services codes

In correlation with these changes, typical times were added to the initial observation codes 99218–99220. Finally, the inpatient neonatal and pediatric and neonatal critical care services subsection guidelines were revised to differentiate professional and facility reporting, as well as add language to assist in the transfer of care of the patient to another physician.

Surgery

In the integumentary subsection, 24 codes were deleted, six codes were revised, nine codes were added, and certain subsection guidelines were revised.

The section title for wound care management and skin substitutes was revised to "Skin Replacement Surgery." The guidelines clarify the intent and use of these services, including definitions describing surgical preparation, autografts/tissue-cultured autografts, and skin substitute grafts.

Based on current clinical practice, a new subsection titled "Skin Substitute Grafts" was added, featuring eight new codes and guidelines that direct coding professionals to separately report the supply of the skin substitute graft(s). Specific instruction is provided related to the use of new code 15777 for biologic implant for soft tissue reinforcement.

In the respiratory subsection for the lungs and pleura procedures, the guidelines were revised, eight codes were deleted, 18 codes were added, and 22 codes were revised to reflect current practice. The new guidelines differentiate the procedure approaches: percutaneous, thorascopic (video-assisted thorascopic surgery [VATS]), and thoracotomy.

The guidelines further differentiate the types, location, and amount of tissue removed and the intent of the procedure as diagnostic or therapeutic. This important delineation will assist users when the diagnostic procedure results in a more extensive procedure performed at the same session.

In addition the new guidelines address the use of intraoperative pathology to determine whether these more extensive procedures are required.

In correlation with these changes, several instructional parenthetical notes and cross-references were added throughout the section. The parenthetical notes and cross-references provide further clarification in reporting these procedures. The extensive changes to the lungs and pleura subsection should help users clearly report the procedures performed.

Changes to the cardiovascular subsection are found largely within the pacemaker codes, where a new table was added for 2012. The table lists codes for both pacemaker systems and implantable cardioverter-defibrillators based on the procedure performed.

Along with revisions to 14 codes and the addition of nine codes, the moderate sedation symbol has been added to many of the pacemaker codes. Instructional guidelines and definitions were added to clarify the intent and use of these codes.

Another significant change in the cardiovascular subsection involves the reporting of arteriovenous (AV) shunts for dialysis. New guidelines for diagnostic studies of AV shunts for dialysis clarify codes 36147 for introduction of a needle or catheter and 36215 for selective catheter placement. New guidelines for interventions for AV shunts created for dialysis were also added to help report these procedures.

The moderate sedation symbol was also added to several selective catheterization procedures, and three new codes were added for insertion, replacement, and retrieval of intravascular vena cava filter.

Changes in the surgery section also occurred in the musculoskeletal and nervous system subsections, including revisions to the spinal instrumentation codes and new guidelines and codes for image-guided neurolysis of facet joint nerve(s).

Radiology

The radiology section includes a revision to code 70355 for orthopantogram to include the example "panoramic x-ray" to better reflect the intent of the code. Code 74174 was also added for computed tomographic angiography (CTA). This single code combines a CTA of the abdomen and pelvis with contrast and includes noncontrast images when performed and image postprocessing.

To coincide with the addition of 74174, several instructional parenthetical notes were added throughout the radiology section instructing users to report the new combined CTA code when performed on the abdomen and pelvis, rather than the single codes for CTA of the abdomen (e.g., 74175) and CTA of the pelvis (e.g., 72191).

In the radiation oncology subsection, the radiation treatment management guidelines were revised to reference new code 77469 for intraoperative radiation treatment management. The guidelines clarify that this code represents only the intraoperative session management and does not include medical evaluation and management outside of that session.

Pathology

The largest change to the pathology section is the introduction of the new molecular pathology subsection, which includes new guidelines and 101 new codes.

As the new guidelines state, "Molecular Pathology procedures are medical laboratory procedures involving the analyses of nucleic acid to detect variants in genes that may be indicative of germline (e.g., constitutional disorders) or somatic (e.g., neoplasia) conditions, or to test for histocompatibility antigens (e.g., HLA)."

The codes are split between 92 tier I codes and nine tier II codes. The difference between the two tiers is the volume in which the procedures are performed, with the tier II codes performed in lower volumes than the tier I procedures.

For the purposes of CPT reporting, the molecular pathology guidelines include definitions that apply to the tier I and tier II codes.

Medicine

Several changes were made throughout the medicine section, including significant revisions within the pulmonary subsection. Ten codes were deleted and new codes were added for pulmonary function testing to reflect commonly performed procedures.

As part of these revisions, the new heading "Pulmonary Diagnostic Testing and Therapies" was added along with guideline revisions providing new instructions for existing codes, as well as four new codes.

Also included for 2012 is a new table in the cardiac catheterization subsection that provides guidance based on the catheter placement type and additional services performed for reporting cardiac catheterization procedures.

The neurology and neuromuscular subsection experienced changes in both the sleep medicine and electromyography areas. The sleep medicine guidelines were revised to include definitions to help report these procedures. In electromyography, three new add-on codes were created to describe needle electromyography procedures when performed in conjunction with nerve conduction studies.

Additional changes can be found throughout the medicine section in several subsections, including immunization administration, special otorhinolaryngologic services, and ophthalmology.

Appendix A

Appendix A includes a new modifier for preventive services and a revision to laboratory modifier 92. In response to the Affordable Care Act, modifier 33 was added to identify a service as a preventive service. The act requires healthcare plans cover preventive services and immunizations without any cost sharing. Appending modifier 33 identifies that the service was preventive and patient cost sharing does not apply under applicable law.

Modifier 92 was revised to include new laboratory code 87389 in the list of codes that can be reported with the modifier.

Since this brief summary does not reflect the numerous changes that occurred throughout every section of the 2012 CPT code set, users are directed to reference the CPT code set in its entirety.

For additional information, the American Medical Association's CPT Changes 2012: An Insider's View offers insight and clarification for every code and guideline change, as well as clinical examples and descriptions of procedures.

Karen O'Hara (karen.ohara@ama-assn.org) is a senior coding specialist at the American Medical Association.

Article citation:
O'Hara, Karen. "CPT Code Updates for 2012." *Journal of AHIMA* 83, no.2 (February 2012): 56-58.