CY 2019 CPT Code Update

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Calendar year (CY) 2019 brings robust changes to the CPT code set with 212 new codes, 73 deleted codes, and 50 revised codes. That puts the total number of CPT codes at an all-time high of 10,294. This article will highlight some of the CPT changes, focusing on the surgical CPT codes.

The tables on below offer a breakdown of the overall changes, as well as a breakdown of the body system subsection changes for the surgery subsection.

CY 2019 CPT Changes Overview

Code Type	Codes Added	Codes Deleted	Codes Revised
Evaluation and Management	6	0	5
Anesthesia	0	0	0
Surgery	34	20	6
Radiology	10	6	4
Pathology/Laboratory	95	5	15
Medicine	29	13	17
Category III	38	29	3
Totals for Codes	212	73	50

Surgery Subsections

CPT Surgery Subsections	Codes Added	Codes Deleted	Codes Revised

Integumentary	15	3	1
Musculoskeletal	4	2	0
Respiratory	0	1	0
Cardiovascular	9	2	3
Lymphatic/Hemic	1	0	0
Digestive	2	3	0
Urinary & Male Reproductive	3	1	0
Nervous	0	7	2
Eye or Endocrine	0	1	0
Totals for Codes	34	20	6

Overview of Changes in Surgery Subsections

The 2019 update saw several CPT code changes in the surgery subsections. Below are some of the highlights.

Integumentary System

Most of the changes in the surgery subsections have to do with the integumentary system. There are two new sets of biopsy codes. The first set involves updates to fine needle aspiration (FNA) biopsy codes. The old code of 10022 for FNA with imaging guidance was deleted. Code 10021 was updated to describe FNA without imaging guidance of the first lesion. Code +10004 was added for FNA without imaging guidance of each additional lesion. Imaging may not always be needed if the mass or lesion is clearly visible. There are eight more new codes (10005-10012) that describe FNA by type of imaging guidance with add-on for each additional lesion. The imaging guidance in the codes include ultrasound, fluoroscopic, CT, and MRI. Coding professionals will now have to really study the procedure note to determine what type of guidance was used, if any, and if additional lesions were biopsied. Coders may also want to review the difference between FNA and core needle biopsies. FNA biopsy is performed when material is aspirated with a fine needle, percutaneously, and the cells are examined cytologically. A CORE needle biopsy is typically performed with a larger bore needle to obtain a core sample of tissue for histopathologic evaluation. CORE needle biopsies are coded within the body system subsections and are not fine needle aspirations.

The real challenge to the FNA biopsy codes come into play when there are multiple types of imaging used on different lesions, or if there is both a FNA and CORE biopsy done of the same lesion—leaving many coders unsure how to proceed. In such an instance, the coder should follow these guidelines:

- If FNA and CORE biopsies are done on the same lesion, same session, same day, same type of imaging guidance, do not separately report the imaging guidance for the CORE biopsy code, but report the "without imaging guidance" code with modifier -59. For example:
    - 10007, FNA biopsy including fluoroscopic imaging first lesion
    - 19100-59, Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure). Report this code without guidance. The same imaging guidance should not be reported twice.
- If FNA and CORE biopsies are done on separate lesions, same session, same day, same type of imaging guidance, report both types of biopsies with imaging guidance, with modifier -59 on the second.

The next set of biopsy codes added were six new codes (11102-11107) that depict the type of biopsy, each type with an add-on code. There are three types of skin biopsies. The first is tangential, which is a scoop, saucerize, shave, or curette type of biopsy removal. The second type is a punch biopsy, which uses a punch tool, and the last type is incisional biopsy of skin using some type of sharp blade. There is a hierarchy with incisional biopsy being the most involved, followed by punch, and finally by tangential. If a coder has a case where there are two lesions biopsied by different means, one tangential and one incisional, then the primary code for the incisional biopsy would be assigned, followed by the "add-on" code for the tangential skin biopsy. Coders will also need to read the operative report carefully so that they do not confuse a punch skin biopsy with an actual full lesion removal via a punch excision. A punch excision takes a small margin around the lesion. This is not a biopsy, but a lesion removal. Also, coders should not confuse a "tangential shave" biopsy with an actual shave removal of the entire lesion (codes 11300-11313).

New Category III codes 0512T-0513T were created for extracorporeal shock wave therapy for integumentary wound healing.

Musculoskeletal

New add-on codes were developed for osteoarticular, hemicortical intercalary, partial and intercalary, complete (+20932-34) allografts. These are usually cadaver bone and will typically be used with codes for radical resections of bone tumors, such as osteosarcomas. Osteoarticular includes articular surface and contiguous bone. Intercalary is cylindrical and hemicortical intercalary, partial, is hemicylindrical. Other new codes include injection for contrast knee arthrography or contrast-enhanced CT/MRI knee arthrography and insertion or removal or both of sinus tarsi implant, which treats over-pronation and mobile flat foot.

Cardiovascular

The first group of additions in the cardiovascular subsection involves new codes for a leadless pacemaker. The leadless pacemaker is placed directly in the heart in the right ventricle, which eliminates the need for a subcutaneous pocket. The codes are 33274 for insertion or replacement of leadless pacemaker and 33275 for removal. These had been Category III codes 0387T-0388T last year, so the procedure is not new.

There are two new codes for insertion and removal of cardiac rhythm monitor. This is also known as a cardiac event monitor or insertable loop recorder. It continuously records rhythms triggered by irregular heart rates.

One new code was created for transcatheter implantation of wireless pulmonary artery pressure sensor. This monitor is for patients with class III heart failure. There is now a code for replacement of aortic valve with the patient's own pulmonary valve (33440). The patient then receives a pig valve in the place of the pulmonary valve. This is because the native pulmonary valve gets less "traffic" than the aortic valve, so a pig valve works well in its place. The patient's own pulmonary valve is better suited to take on the workload of the aortic valve it is replacing. This is also known as the Ross-Konno procedure. One new add-on code, +33866, was added to report hemiarch graft that is used in ascending aortic graft replacement surgery, which is coded separately.

Peripherally inserted central venous catheter codes 36568-36584 were revised or created for "without imaging guidance" and "including all imaging guidance, image documentation." The imaging guidance used is usually fluoroscopy and ultrasound. All supervision and interpretation (S&I) with the guidance is also included in the codes.

New Category III codes were created for insertion and removal of various components of a wireless cardiac stimulation device. The WiSE CRT system from EBR is one example. This device is used for left ventricular pacing and resynchronization of the heart. The stimulation is accomplished using components from a previously implanted conventional device such as a pacemaker that are activated by the wireless cardiac stimulation system.

One new Category III code, 0505T, was created for endovenous femoral-popliteal artery revascularization, or bypass stent graft. In this procedure, the stent graft exits the artery and then is placed in the adjacent vein—usually the femoral vein—until it is around the arterial blockage. Then the stent graft is brought into the artery again. If the stent graft does not enter the adjacent vein, then it is not coded to 0505T.

There are also new Category III codes for coronary fractional flow reserve, endovenous catheter-directed chemical ablation with balloon isolation of incompetent extremity vein, and insertion removal, programming and interrogation of an intracardiac ischemia monitoring device.

Digestive

Two new codes (43762, 43763) were added to distinguish replacement of gastrostomy tube, percutaneous, without imaging, either not requiring revision of gastrostomy tract, or requiring revision of gastrostomy tract. There are other existing codes for gastrostomy tube replacement under fluoroscopic guidance and for endoscopically placed gastrostomy tube. So, the coder is cautioned to pay attention to the method used to replace a gastrostomy tube. Old code 43760 was deleted.

Urinary

Two new codes were created to help clear up confusion regarding dilation of a nephrostomy tract or creation of a new tract. One new code, 50436, is for dilation of an existing nephrostomy tract for the purpose of inserting larger instruments for an endourological procedure. It includes post-procedure nephrostomy tube placement, all imaging guidance, and S&I. The second code, 50437, is for creation of a new access, and includes all the elements of 50436. Code 50395 was deleted. These changes will help the coder better understand what is included in these procedures.

New code 53854 replaces HCPCS code C9748 for transurethral destruction of prostate tissue by radiofrequency-generated water vapor therapy.

Category III Code Changes

Some of the new surgical Category III codes have been covered above. Many of the new codes have to do with diagnostic testing or non-surgical procedures. Hospitals may report some of these codes via chargemaster charging at the departmental level. Examples include 0533T-0536T, Continuous recording of movement disorder symptoms and 0537T-0542T, Chimeric antigen receptor T-cell (CAR-T) therapy. Coders are urged to peruse the Category III code section of CPT to look for procedures that are performed at their facilities. Work with hospital departments on how these codes will flow to the claim. Many can be placed on the chargemaster.

Radiology, Laboratory, Medicine Changes

Since many of these codes are chargemaster-driven, this section won't go into detail regarding the changes. For Radiology there are 10 new codes, six deleted, and four revised. Changes include six new ultrasound and ultrasound with elastography codes and four new magnetic resonance imaging of breast codes.

For the Medicine section there are 29 new codes, 13 deleted, and 17 revised. This includes one new code, 93264, for remote monitoring of wireless pulmonary artery pressure sensor and seven new or revised neurostimulator monitoring codes. A new "Adaptive Behaviour Services - Assessments – Treatment" subsection is new along with other central nervous system testing codes.

For Laboratory and Pathology sections, there are 95 new codes, five deleted codes, and 15 revised codes. Most of the new codes encompass molecular pathology codes, a growing area in pathology.

Evaluation and Management Changes

For Evaluation and Management, the term "Electronic Health Record" was added to the subsection "Interprofessional Telephone/Internet Consultations" and notes to denote the increased use of the online electronic health record "visits." Two new codes, 99451-99452 were created to denote various times for "Interprofessional telephone/internet/electronic health record assessment and management service" provided by a consultative physician or referral services provided by a treating/requesting physician.

New subsections for "Digitally Stored Data Services/Remote Physiologic Monitoring" and "Remote Physiologic Monitoring Treatment Management Services" have been created to include four new codes and one revised code. This is a much-needed area for CPT as more and more patient data becomes digitized and is managed and assessed by the physician after download.

One new code has been created, 99491, Chronic care management services provided personally by a physician or other QHCP at least 30 minutes of physician/QHCP time, per calendar month. There are required elements for this code.

The coder who assigns the above evaluation and management codes should read the extensive notes included in the CPT introduction to this subsection. It is mandatory to follow these instructional notes.

Appendix L Expansion

Coders will find that the American Medical Association has expanded Appendix L, Vascular Families to include detailed diagrams of vessels and the appropriate order for normal anatomy.

Further Review of Changes

In summary, this article was a brief overview of the CPT changes for CY 2019. Coding professionals must fully review the CPT code book instructional and code notes, as well as documentation and reimbursement requirements, to be fully proficient in assigning these new codes.

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Article citation:
Maccariella-Hafey, Patricia. "CY 2019 CPT Code Update." *Journal of AHIMA* 90, no. 3 (March 2019): 40–43.