Sign of the Changing Times: CPT 1999

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This year brought with it 686 changes to CPT. While this is a moderate number in comparison to previous years, several of the changes have significant impact on code assignment. The purpose of this article is to highlight some of the areas of significant change. (See "1999 CPT Revisions" in the January 1999 *Journal of AHIMA* for an overview of CPT 1999 revisions.) *Note: Medicare or other third-party payers may have a different perspective with the use of the coding changes.*

Modifiers

Two major changes were made in the presentation of modifiers. First, the familiar listings of modifiers that previously appeared at the beginning of most CPT sections were moved to Appendix A. For instance, the commonly used modifiers associated with E/M codes are now found in Appendix A. An exception to this is found in the surgery guidelines section, where an abbreviated list of modifiers used for reporting more than one procedure/service during the same day or post-operative period is provided. To see a complete listing of commonly used modifiers, coders must now reference Appendix A.

The second major change is that Appendix A was split into two sections: "Modifiers," containing all CPT 1999 modifiers and "Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use." For ease of use, the modifiers used for ambulatory surgery centers and hospitals are further divided into Level I Modifiers (CPT modifiers) and Level II Modifiers (HCPCS/national modifiers).

Symbols

Two new symbols were added to aid in proper code assignment. The first symbol, +, appears before add-on codes. Consider the entry from CPT in

Figure 1.

11100*	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion
+ ●11101	each separate/additional lesion (List separately in addition to code for primary procedure) (Use 11101 in conjunction with code 11100)

Figure 1

When a patient has three skin lesions biopsied, codes 11100, 11101, and 11101 are used. Code 11101 may not be used alone. So in addition to the +, the parenthetical note "Use 11101 in conjunction with code 11100" follows code 11101. For a complete list of add-on codes, see Appendix E.

The second new CPT symbol is ⃠. This symbol is used to identify codes that may not be appended with the modifier -51, Multiple procedures. For example, see code 20912, Cartilage graft: nasal septum. Appendix F contains a summary of CPT codes exempt from modifier -51.

Use of Operating Microscopes

A new code was added to identify the use of an operating microscope. This new code, 69990 -- *Use of operating microscope (List separately in addition to code for primary procedure),* has taken the place of the deleted modifier -20, Microsurgery.

Even though code 69990 appears following the auditory subsection, its use is not limited to this subsection. When appropriate, it may be used throughout the surgery section of CPT. To help the coder identify situations when code 69990 should not be assigned, CPT has included an extensive exclusion note before the text of the code 69990. In addition to this entry, directional

notes have been added after codes that may not be used in conjunction with code 69990. For example, code 15756, Free muscle flap with or without skin with microvascular anastomosis, would be cited in the exclusion note above code 69990, along with a directional note after code 15756, directing the coder not to report 69990 in addition to code 15756. Only 15756 would be used.

Bronchoscopies

This year a note of explanation was added to the trachea and bronchi endoscopy section indicating that fluoroscopic guidance is included in codes 31622-31646. Fluoroscopic equipment serves as an image intensifier and is frequently used during bronchoscopies. It is incorrect to use an additional code to identify fluoroscopy.

A major revision has been made in the codes used to identify bronchoscopies. The code 31622, Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing, now only identifies the washings. A new code, 31623, Bronchoscopy; with brushing or protect brushings, was created to exclusively identify a bronchoscopy with brushings. In order to obtain a brushing, the physician may use a fixed brush or a protected specimen brush. The advantage of using a protected specimen brush is that it minimizes the risk of contaminating the specimen with upper airway flora.

Another new code, 31624, Bronchoscopy; with bronchial alveolar lavage was added to the bronchoscopies series. Bronchial alveolar lavage is a process that instills sterile saline into the airway. The saline is then suctioned out and sent for cytological or microbiological examination.

A palliative treatment for non-resectable lung cancer is brachytherapy. Code 31643, Bronchoscopy; with placement of catheter(s) for intracavitary radioelement application, is the new code used to identify this procedure. Under bronchoscopy, a catheter containing the radioactive material is positioned next to the tumor. CPT directs the coder to assign two codes: 31643 to identify the bronchoscopic catheter placement and 77761-77763 or 77781-77784 to identify the intracavitary radioelement application.

Also added was code 32001, Total lung lavage (unilateral). This should not be confused with bronchial alveolar lavage, as described with code 31624. A total lung lavage is an extensive procedure that may include 10 to 15 whole lung lavages during a single lavage procedure. This procedure may take up to a half day to complete. The coder should note that code 32001 is specified as unilateral. Therefore, modifier -50, Bilateral procedure, would be appropriate to use if a bilateral total lung lavage was performed.

Integumentary System

One of the most significant changes to the integumentary system codes occurs with the use of the codes in Figure 2.

Figure 2

● 15000	Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 square cm or one percent of body area of infants and children	Code 15000 now reflects the size of the recipient site associated with excision of open wound, burn eschar, or scar. If the recipient site is greater than 100 square cm, code 15000 plus the new add-on code, 15001, is assigned. Code 15001 reflects each additional 100 square cm or each 1 percent of body area for infants and children. For example, if the recipient site was 300 square cm, codes 15000, 15001, and 15001 are assigned.
+ ●15001	each additional 100 square cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)	

Another major change involving code 15000 is the deletion of the terminology referring to removal of a skin lesion with subsequent free skin graft. Rather than including the excision of a lesion, CPT 1999 directs the coder to use a code in the range of 11400-11471 or 11600-11646 to identify the excision of the lesion plus codes from the free skin graft range. As in any coding situation, individual payers should be consulted to obtain reimbursement guidelines before initiating changes in coding policies.

Finally, codes representing destruction of lesions have been modified. The code assignment for the destruction of 15 or more lesions was collapsed into revised code 17004. In the previous edition of CPT, several codes would have been used to identify the destruction of 16 skin lesions. In CPT 1999, only 17004 would be assigned.

Immunizations

To aid in the accurate reporting of immunizations, 27 new vaccine/toxoid codes were added. To help identify the appropriate code within the new list, Suzanne M. Feikema of the Centers for Disease Control and Prevention (CDC) developed vaccine/toxoid code tables. To find these tables, go to http://www.cdc.gov/nip/registry/cpt-cvxb.htm.

Figure 3

● 90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular, and jet injections and /or intranasal or oral administration); single or combination vaccine/toxoid	To report the administration of a vaccine or toxoid, assign two codes. One code will identify the vaccine or toxoid, and the second code will identify the administration. Two new codes were created to identify the administration of vaccines. (See Figure 3.)
● 90472	two more single or combination vaccines/ toxoids	These codes are to be used with vaccine/toxoids only. If immune globulins are administered, a code in the 90780-90784 range should be used.

Summary

Although CPT 1999 contains fewer changes than in past years, coders should take some time to learn them by:

- familiarizing themselves with the new symbols + and ⃠
- reviewing Appendix A for a complete list of modifiers as well as modifiers used in the ambulatory surgery center hospital outpatient setting
- reviewing Appendix E for a complete list of add-on codes
- reviewing Appendix F for a list of modifier -51-exempt codes
- consulting the excludes note found above code 69990 to identify procedures exempt from the use of the new operating microscope code
- examining the specific codes used to identify bronchoscopic procedures
- reviewing the parenthetical notes found after code 15001, directing the coder to also assign the appropriate code for lesion excision
- reviewing the changes associated with the coding of destruction of lesions
- understanding the changes in immunization code assignment
- consulting payers for specific reimbursement guidelines

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Article citation:
Mallett, Sherri, and Gail I. Smith. "Sign of the Changing Times: CPT 1999." *Journal of AHIMA* 70, no.6 (1999): 70-73.
