



Compliance Compass

Vanderbilt University Medical Center Office of Compliance and Corporate Integrity

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2009 CPT Updates

For 2009 there are approximately 520 code changes. This includes 291 new codes; 134 revised codes; and 95 deleted codes. The following is a breakdown of the changes by section.

Anesthesia – 2 codes added and 2 codes revised.

Evaluation and Management – 17 codes added, 15 codes were deleted, and 18 codes were revised.

Surgery – 33 codes added, 11 codes were deleted, and 59 codes were revised.

Radiology – 4 codes added, 6 codes were deleted, and 1 code was revised.

Path & Lab – 7 codes added and 20 codes were revised.

Medicine – 67 codes added, 37 codes were deleted, and 22 codes were revised.

Category II & III – 161 codes added, 26 codes were deleted, and 12 codes were revised.

2009 Physician and Anesthesia Conversion Factors

The following information identifies some of the changes; however, it is important to review the CPT book for specific changes related to each specialty.

The 2009 physician fee schedule will receive a 1.1% increase. Based on that update, the 2009 conversion factor (CF) is \$36.0666. Although MIPPA calls for a 1.1% increase, the new conversion factor is actually a decrease from the conversion factor of \$38.087 for 2008. Because the budget neutrality adjustment required by MIPPA for 2009 has been shifted from the practice expense (PE) RVU's to the work RVU's, CPT codes with higher Work versus Practice RVUS will see an increase in the actual payment.

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Examples of the actual 2009 payment rate changes for some of the evaluation and management (E/M) services are listed below.

CPT Code	2009	2008
99213	57.89	56.13
99214	87.26	84.47
99215	118.13	114.36
99202	59.45	57.77
99203	86.21	84.76
99204	134.00	130.29
99205	169.52	163.99
99242	85.15	82.97
99243	117.15	114.08
99244	174.31	168.36
99245	214.32	207.80
99221	86.65	81.70
99222	118.25	112.28
99223	174.13	165.23

The anesthesia conversion factor for 2009 is \$20.9150. The 2008 anesthesia conversion factor was \$22.081.

New Pediatric Codes

Many pediatric codes have been deleted. They were replaced by new codes so the services would flow more appropriately in the CPT book.

Description	New Code	Old Code
Initial hospital or birthing center code per day of normal newborn	99460	99431
Initial care per day for newborn seen in other than hospital or birthing center	99461	99432
Subsequent hospital care, per day, for normal newborn	99462	99433
Initial hospital or birthing center care, per day, for a newborn admitted and discharged on the same date	99463	99435
Attendance at delivery and initial stabilization of newborn	99464	99436
Delivery/birthing room resuscitation, provision positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	99465	99440

Critical care services delivered by a MD, <u>face-to-face</u> during an interfacility transport of critically ill or injured pediatric patients, 24 months of age or less, first 30-74 minutes.	99466*	99289
Same as above for each additional 30 minutes	99467	99290

*Face-to-face care begins when the MD assumes primary responsibility for the patient at the referring hospital and ends when the receiving hospital accepts responsibility. The MD providing direct emergency care through outside voice communication to transporting staff personnel should continue to use code 99288.

New PICU and NICU Codes

Description	New Code	Old Code
Initial neonatal critical care per day for critically ill neonate 28 days of age or less	99468	99295
Subsequent inpatient critical care per day for critically ill neonate 28 days of age or less	99469	99296
Initial inpatient pediatric critical care per day for critically ill infant or young child, 29 days through 24 months of age	99471	99293
Subsequent inpatient pediatric critical care per day for a critically ill infant or young child, 29 days through 24 months of age	99472	99294
Initial inpatient pediatric critical care for critically ill infant or young child, 2 to 5 years of age.	99475	N/A
Subsequent inpatient pediatric critical care for a critically ill infant or young child, 2 to 5 years of age.	99476	N/A
Subsequent intensive care per day of the recovering very low birth weight infant, present birth weight less than 1500 grams	99478	99298
Subsequent intensive care per day of the recovering infant, 1500-2500 grams present weight	99479	99299
Subsequent intensive care per day of the recovering infant, 2501-5000 grams present weight	99480	99300

Urology

New codes have been created for billing prostate saturation biopsies. CMS created four “G” codes for prostate saturation biopsy for CY 2009 as follows:

G0416 Saturation biopsy prostate 1-20 specimen
G0417 Saturation biopsy prostate 21-40 specimen
G0418 Saturation biopsy prostate 41-60 specimen
G0419 Saturation biopsy prostate >60 specimen

In addition, CPT code 55706 was added to replace 0137T. The new code was established to report transperineal biopsies of the prostate using stereotactic template guidance. The transperineal saturation biopsy procedures are not lesion oriented but rather systematic collections of samples in those areas of the gland where tumors are most frequent. Patients generally have 30-60 specimens taken for sample to address the nature of prostate cancer and for the accurate diagnosis of prostate cancer.

Preventive Physical Examination

The “Welcome to Medicare” or Initial Preventive Physical Exam (IPPE) examination code has been modified for 2009. Newly eligible Medicare beneficiaries can obtain the IPPE for the first 12 months after the effective date of their first Part B coverage period. Previously it was only 6 months. Also the Part B deductible does not apply to the IPPE if performed after 1/1/09. CMS also added (a) the measurement of an individual’s body mass index, (b) end-of-life planning; and (c) removed the EKG from the list of mandated services. CMS will pay for one IPPE per beneficiary lifetime. Use G0402 for the Initial Preventive Physical Exam and G0403 for the routine ECG with at least 12 leads with interpretation and report. The 4 existing codes G0344, G0365, G0366 and G0367 will be deleted as of 1/1/09.

Ophthalmology

Code 65756 Keratoplasty (corneal transplant) was added to report the replacement of the inner most layers of the cornea called the endothelium. The procedure is also referred to as DSEK Descemet’s Stripping Endothelial Keratoplasty and DSAEK Descemet’s Stripping Automated Endothelial Keratoplasty. Code 65757 is an add-on code that is used for reporting the surgeon’s preparation of the endothelial graft material in the OR prior to performing the intraocular surgery. The code is not to be used with keratoplasties other than 65756.

Cardiology

To address changes in clinical practice and allow the performance and interpretation of contrast enhanced echocardiography before and during stress to be reported, the Echocardiography section of the CPT codebook was updated. There is a new Echocardiography code 93306 which will be used to report a complete transthoracic echo spectral and color flow Doppler in addition to the 2-d and selected M-mode exams. The prior main echo code 93307 now specifies without spectral or color Doppler echo. It would be inaccurate to report 93307 in conjunction with 93320, 93321, 93325.

A new code, 93351, describes a stress echo (93350) and an associated complete stress test (93015) when performed by the same MD in a non-facility setting. Codes billed in a facility setting

(hospital) would include 93350 and one or more of the professional component codes 93016 and/or 93018. [It will be important to select the proper codes depending on the site of service.](#)

There is a new code for contrast agent utilization during a stress echo. Code 93352 is used for echocardiography contrast agent during stress. This is an add-on code and should be reported once per stress echocardiogram. The supply of contrast agent and/or drugs used is reported separately. A contrast agent is considered medically necessary when used to improve delineation of left ventricular endocardial borders for those whose non-contrast is inadequate and when LV function assessment is essential for management.

Cardiac Monitoring

There are many changes in the cardiography section of the CPT code book. New definitions include: Attended surveillance which is defined as the immediate availability of a remote technician to respond to rhythm or device alert transmissions from a patient, either from an implanted or wearable monitoring or therapy device, as they are generated and transmitted to the remote surveillance location or center. There is also clarification of several codes to indicate “wearable” device monitoring as opposed to implanted device monitoring.

The current monitoring codes 93224, 93230, 93235, and 93268 have editorial revisions to specify that the codes are to be utilized for a) wearable devices only and b) do not include monitoring of physiologic data: electronic monitoring has become wearable electrocardiographic rhythm derived monitoring.

New codes include:

Code 93228 - Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis. In order for this code to be billable the device must be worn for at least 10 days.

Code 93229 - Technical support for connection and patient instructions for use. This code can only be reported once per 30 days and requires 24/7 monitoring.

Device Code Revisions

Codes 93727-93736 and 93741-93744 have been deleted. Twenty-one new codes were created. There is now a separation of codes for reporting ECG rhythm derived elements from physiologic data, even when the same device provides both.

Summary of Definitions

Device Type	Lead Configurations	Evaluation/Service
Pacemaker	Single Lead	Interrogation device evaluation (in person and remote)
Cardioverter-defibrillator (ICD)	Dual Lead	Programming device evaluation (in person)
Loop recorder (ILR)	Multiple Lead	
Cardiovascular monitor (ICM)	Physiologic Data	

Programming Device Evaluation Codes

In Person

Leads	Pace maker	ICD
Single Leads	93279	93282
Dual Leads	93280	93283
Multiple Leads	93281	93284

For programming device evaluation of an implantable loop recorder, use 93285.

Interrogation Device Evaluation Codes

In Person

Leads	Pacemaker	ICD	CV Monitoring System	Loop Recorder System
Single, dual or multiple leads; all MD analysis reviews & reports	93288	93289	93290	93291

For Interrogation Device Evaluation of a Wearable Defibrillator System use 93292.

Interrogation Device Evaluation Codes

Remote

Leads	Pacemaker	ICD	CV Monitor System	Loop Recorder System
	Report once per 90 days	Report once per 90 days	Report once per 30 days	Report once per 30 days
Single, dual or multiple leads; all MD analysis, review and reports	93294	93295	93297	93298
Remote data acquisition, receipt of transmissions and technician review, technical support and distribution of results	93296	93296	93299	93299

There are two new codes for peri-procedural device evaluation and programming. 1.) 93286 Peri-procedure device evaluation and programming of device system parameters before or after surgery, procedure or test with MD analysis with review and report. 2.) 93287 single, dual, or multiple lead implantable cardioverter-defibrillator system.

Code 93293 replaces both 93733 and 93736 resulting in one new code for transtelephonic rhythm strip analysis of all pacemakers regardless of the number of leads. This service can be reported only once per 90 days.

ESRD Physician Services

Codes 90918 - 90925 for ESRD physician services have been deleted. The new codes are 90951-90970. Codes 90951-90962 are reported once per month to distinguish age-specific services related to the patient's ESRD performed in an outpatient setting with 3 levels of service based on the number of face-to-face visits. ESRD-related MD services include the establishment of the dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls, and patient management during the dialysis provided during a full month. In the cases where the patient has had a complete assessment visit during the month and services are provided over a period of less than a month, codes 90951-90962 are used based on the number of visits performed.

Codes 90963-90966 are reported once per month for a full month of services to distinguish age-specific services for ESRD for home dialysis patients. For ESRD and non-ESRD dialysis services performed in an inpatient setting, and for non-ESRD dialysis performed in an outpatient setting, continue to use codes 90935-90937 and 90945-90947.

Do not separately report E&M services unrelated to ESRD performed during the dialysis session. Report codes 90967-90970 to distinguish age-specific services for ESRD services for less than a full month of service, per day. For reporting purposes, each month is considered 30 days.

Neurosurgery - Radiosurgery

Code 61793 for stereotactic radiosurgery has been deleted. To report these services use 61796 – 61800 for cranial lesions or 63620 – 63621 for spinal lesions. Codes 61796 and 61797 involve stereotactic radiosurgery for simple cranial lesions less than 3.5 cm in maximum dimension. Report code 61796 when all lesions are simple. 61798 and 61799 are used for complex cranial lesions and procedures that create therapeutic lesions. All lesions 3.5 cm in maximum dimension or greater are considered complex. Any lesion adjacent (5mm or less) to the optic nerve/chiasm/tract or within the brainstem are also considered complex. 61798 is reported only once regardless of the number of lesions created. When treating multiple lesions with any single complex lesion report the service as 61798. Codes 61796 – 61799 include computer-assisted planning and would not be reported with code 61795.

General Surgery

There is a new code 46930 used for billing hemorrhoid destruction procedures using thermal energy (infrared, electrical, radiofrequency). This addition resulted in the deletion of 3 codes 46934, 46935, and 46936. There is also a new code, 43279, to recognize laparoscopic procedures used to perform Heller myotomy that traditionally has been performed using open surgical techniques.

Codes 49652-49657 were added to report laparoscopic repairs performed for hernias.

Repair	Laparoscopic Code	Open Code
Ventral, umbilical spigelian, epigastric; reducible	49652	49560, 49570, 49580, 49590
Ventral, umbilical spigelian, epigastric; incarcerated	49653	49566, 49572, 49587
Incisional; reducible	49654	49560
Incisional; incarcerated	49655	49561
Recurrent incisional; reducible	49656	49565
Recurrent incisional; incarcerated	49657	49566