

INGENIX®

CPT® Expert

2006

6th edition

Introduction

Welcome to the Ingenix *CPT Expert*, the definitive procedure coding source that combines the work of the American Medical Association (AMA) with the technical components you need for proper reimbursement and coding accuracy. *CPT Expert* not only provides you with the most recent version of the AMA's Physicians' Current Procedural Terminology (CPT®), but also with detailed coding instructions, clinical guidelines, lay definitions of complex procedures and medical terms, and summaries of the coverage policies used by federal and commercial payers.

CPT Expert includes the information needed to submit claims to commercial payers or federal intermediaries and carriers, and is correct at the time of printing. However, commercial payers and CMS may change payment rules at any time throughout the year. Commercial payers will announce changes through monthly news or information posted on their Web sites. CMS will post changes in policy on its website at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. Local coverage determinations (LCDs) provide individual carrier guidelines for specific services. The existence of a procedure code does not imply coverage under any given insurance plan.

CPT Expert is based on the American Medical Association's Physicians' Current Procedural Terminology (CPT) coding system, which is

copyrighted and owned by the physician organization. CPT is the nation's official, HIPAA compliant code set for procedures and services provided by physicians, ambulatory surgical centers, and hospital outpatient services, as well as laboratories, imaging centers, physical therapy clinics, urgent care centers, and others. ***CPT Expert is not intended to be a replacement for the official AMA CPT manual.***

GETTING STARTED WITH *CPT EXPERT*

CPT Expert combines the most current material at publication time from the American Medical Association's CPT 2006, the Centers for Medicare and Medicaid Services online manual system, the Correct Coding Initiative, CMS fee schedules and rules, and Ingenix's own coding expertise.


Designed to be easy to use and full of information, this product is an excellent companion to your AMA CPT book, Medicare, Ingenix, or other resources. These are presented in black text or through use of an easy-to-spot color bar or icon. Coding guidelines, annotations and tips from Ingenix technical experts are designated in blue ink.


Icons derived from AMA guidelines or coding conventions are presented as circles. Icons derived from federal guidelines, data, or rules are square.


Blue Color Bar—Not Covered by Medicare
Services and procedures identified by this color bar are never a covered benefit under Medicare. Services and procedures that are not covered may be billed directly to the patient at the time of the service.

Yellow Color Bar—Unlisted Procedure
Unlisted CPT codes report procedures that have not been assigned a specific code number. An unlisted code delays payment due to the extra time necessary for review. When using an unlisted procedure code, include cover notes, documentation of medical necessity, and operative reports.


TC Technical Component Only
Codes with this icon represent only the technical component (staff and equipment costs) of a procedure or service. Do not use either modifier 26 or TC with these codes.

11975 Insertion, implantable contraceptive capsules ♀ 


20999 Unlisted procedure, musculoskeletal system, general 

77520 Proton treatment delivery; simple, without compensation 


23 Professional Component
Only codes with this icon represent the physician's work or professional component of a procedure or service. Do not use either modifier 26 or TC with these codes.

77427 Radiation treatment management, five treatments 


20 Bilateral Procedure
This icon identifies codes that can be reported bilaterally when the same surgeon provides the service for the same patient on the same date. Medicare allows payment for both procedures at 150 percent of the usual amount for one procedure. The modifier does not apply to bilateral procedures inclusive to one code.

27235 Percutaneous skeletal fixation of femoral fracture, proximal end, neck 


80 Assist-at-Surgery Allowed
Services noted by this icon are allowed an assist at surgery with payment equal to 16 percent of the allowed amount for the global surgery for that procedure. No documentation is required.

30460 Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only 


80 Assist-at-Surgery Allowed with Documentation
Services noted by this icon are allowed an assistant at surgery with payment equal to 16 percent of the allowed amount for the global surgery for that procedure. Documentation is required.

30400 Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip 


+ Add-on Codes
This icon identifies procedures reported in addition to the primary procedure. The icon "+" denotes add-on codes. An add-on code is neither a stand-alone code nor subject to multiple procedure rules since it describes work in addition to the primary procedure.

22216 each additional vertebral segment (List separately in addition to primary procedure) 


Ⓞ Modifier 51 Exempt
Codes identified by this icon indicate that the procedure does not meet the definition of an add-on procedure and is not subject to multiple procedure rules.

50327 Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each 


12 Correct Coding Initiative (CCI)
CPT Expert identifies those codes with a corresponding CCI edit in Version 11.3, effective October 1, 2005. The CCI edits define correct coding practices that now serve as the basis of the national Medicare policy for paying claims. The code noted is the column 1 (comprehensive) code.

12051 Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less 

23 CLIA Waived Test
This icon identifies laboratory services that are not subject to the latest available Clinical Laboratory Improvement Amendments (CLIA) regulations.

84830 Ovulation tests, by visual color comparison methods for human luteinizing hormone 

Ⓞ Modifier 63 Exempt
This icon identifies procedures performed on infants that weigh less than 4 kg. Because of the complexity of performing procedures on infants less than 4 kg, this modifier may be added to the surgical codes to inform the payers of the special circumstance.

44055 Correction of malrotation by lysis of duodenal bands and/or reduction of midgut volvulus (eg, Ladd procedure) 

INTRODUCTION

I-D ASC Group

This icon identifies a service that is on the latest available list of Medicare covered ASC procedures, and identifies the ASC group, effective July 1, 2005.

50393 Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous **I T 50**

C Conscious Sedation

This icon identifies procedures that include conscious sedation. Conscious sedation codes should not be reported with these procedures.

92986 Percutaneous balloon valvuloplasty; aortic valve **T 80**

A Age Edit

This icon denotes codes intended for use with a specific age group, such as neonate, newborn, pediatric, and adult. Carefully review the code description to assure the code you report most appropriately reflects the patient's age.

49580 Repair umbilical hernia, under age 5 years;reducible **A 4 T 80**

M Maternity

This icon identifies procedures that by definition should only be used for maternity patients generally between 12 and 55 years of age.

59871 Removal of cerclage suture under anesthesia (other than local) **M ♀ S T 80**

♀ Female Only

This icon identifies procedures that should only be reported for female patients.

57220 Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication) **♀ S T 80**

♂ Male Only

This icon identifies procedures that should only be reported for male patients.

52500 Transurethral resection of bladder neck (separate procedure) **♂ S T**

MED: This notation precedes an instruction pertaining to this code in the Centers for Medicare and Medicaid Services' (CMS) new Publication 100 (Pub 100) electronic manual or in a National Coverage Decision (NCD). These CMS sources, formerly called the Medicare Carriers Manual (MCM) and Coverage Issues Manual (CIM), present the rules for submitting these services to the federal government or its contractors and are included in the appendix of this book.

46615 with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique **S T 80**
(MED): 100-2, 15, 260; 100-3, 100.2; 100-4, 12, 90.3; 100-4, 14, 10

AMA: This indicates discussion of the code in the American Medical Association's (AMA) CPT Assistant newsletter. Use the citation to find the correct issue.

46083 Incision of thrombosed hemorrhoid, external **T**
(AMA): 1997, Jun, 10

⚡ Drug Not Approved by FDA

The AMA CPT Editorial Panel is publishing new vaccine product codes prior to FDA approval. This symbol indicates which of these codes are pending FDA approval at press time. Check the Ingenix OnLine Web site (<http://www.ingenixonline.com/content/pn/>) or AMA Web site (<http://www.ama-assn.org/ama/pub/category/3113.html>) for updates to these codes as they pass through the FDA process.

⚡90680 Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use **N**

A–V APC Status Indicators

Status indicators identify how individual CPT codes are paid or not paid under the latest available hospital outpatient prospective payment system (OPPS). The same status indicator is assigned to all the codes within an Ambulatory Payment Classification (APC). Consult your payer or resource to learn which CPT codes fall within various APCs.

A Indicates services that are paid under some other method such as the DMEPOS fee schedule or the physician fee schedule

B Indicates codes that should not be used on an OPPS hospital outpatient bill (types 12X, 13X, and 14X). Codes may be allowable on other types of bills.

C Indicates inpatient services that are not paid under the OPPS

E Indicates services for which payment is not allowed under the OPPS. In some instances, the service is not covered by Medicare. In other instances, Medicare does not use the code in question, but does use another code to describe the service

F Indicates corneal tissue acquisition costs, which are paid separately

G Indicates a current drug or biological for which payment is made under the transitional pass-through

H Indicates a device for which payment is made under the transitional pass-through

K Indicates non-pass-through drugs and biologicals. Effective July 1, 2001, co-payments for these items and the service for the administration of the administration of the items are aggregated and may not exceed the inpatient hospital deductible

L Indicates influenza or pneumonia vaccine paid as reasonable cost with no deductible or coinsurance

M Services not billable to the fiscal intermediary and not payable under OPPS

N Indicates services that are incidental, with payment packaged into another service or APC group

P Indicates services paid only in partial hospitalization programs

S Indicates significant procedures for which payment is allowed under the hospital OPPS but to which the multiple procedure reduction does not apply

T Indicates surgical services for which payment is allowed under the hospital OPPS. Services with this payment indicator are the only service to which the multiple procedure payment reduction applies

V Indicates medical visits for which payment is allowed under the hospital OPPS

X Indicates ancillary services for which payment is allowed under the hospital OPPS

Y Indicates nonimplantable durable medical equipment (DME) that is not paid under OPPS. True DME. Providers other than home health agencies bill to the DMERC.

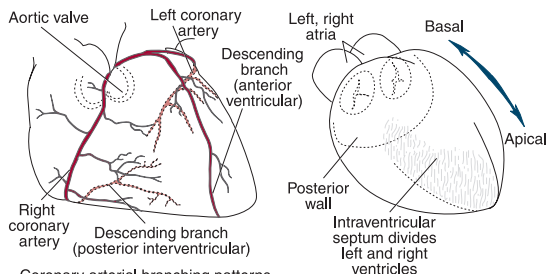
50393 Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous



Current as of 10/31/2005

For more information about ongoing development of the CPT coding system, consult the AMA Web site at URL <http://www.ama-assn.org/>

You may subscribe to an e-mail service to receive special reports when information in this book changes. Contact customer service at 1-800-INGENIX, option 1.



Coronary arterial branching patterns may vary widely; dead heart tissue, usually caused by arterial occlusion, is called a myocardial infarct and about 1.5 million cases are reported annually. Inadequate blood supply can lead to "angina pectoris," or chest pain

Interior heart schematic to locate a myocardial infarction; walls of the left ventricle are much thicker and more than half of MI occurrences will see some degree of transient impairment to the left ventricle

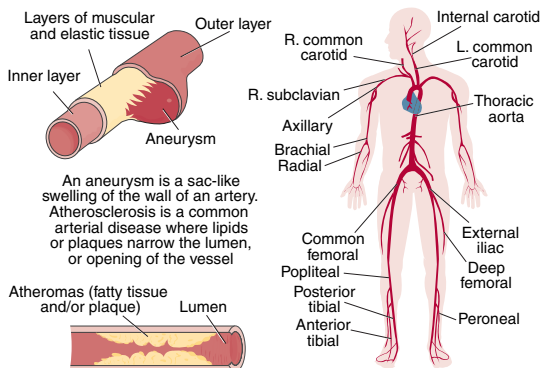
THORACIC AORTIC ANEURYSM

Codes 33880-33891 are used to report placement of an endovascular graft for repair of the descending thoracic aorta. These codes include all the device introduction, manipulation, positioning, and deployment. Do not report balloon angioplasty and/or stent deployment separately. Report open arterial exposure and associated closure of the arteriotomy sites (34812, 34820, 34833, 34834), introduction of guidewires and catheters (36140, 36200-36218), and extensive repair or replacement of an artery (35226, 35286), and transposition of subclavian artery to carotid, and carotid-carotid bypass performed in conjunction with endovascular repair of the descending thoracic aorta (33889, 33891) separately. Codes 33880 and 33881 include placement of all distal extensions. However, if proximal extensions are needed, they should be reported separately.

Consult 75956-75959 for fluoroscopic guidance.

Report other interventional procedures performed at the time of the endovascular repair separately.

- 33860 Ascending aorta graft, with cardiopulmonary bypass, with or without valve suspension; C 30**
- 33861 with coronary reconstruction C 30**
- 33863 with aortic root replacement using composite prosthesis and coronary reconstruction C 30**
- 33870 Transverse arch graft, with cardiopulmonary bypass C 30**
- 33875 Descending thoracic aorta graft, with or without bypass C 30**
- 33877 Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass C 30**



An aneurysm is a sac-like swelling of the wall of an artery. Atherosclerosis is a common arterial disease where lipids or plaques narrow the lumen, or opening of the vessel

ENDOASCULAR REPAIR OF DESCENDING THORACIC AORTA

- **33880** **Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin**
 To report radiological supervision and interpretation, use 75956 with 33880.
- **33881** **not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin**
 To report radiological supervision and interpretation, use 75957 with 33881.
- **33883** **Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension**
 To report radiological supervision and interpretation, use 75958 with 33883.
 Codes 33881, 33883 cannot be reported when extension placement converts repair to cover left subclavian origin. Use only 33880.
- + ● **33884** **each additional proximal extension (List separately in addition to code for primary procedure)**
 Note that 33884 is an add-on code and must be used in conjunction with 33883.
 To report radiological supervision and interpretation, report 75958 with 33884.
- **33886** **Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta**
 Code 33886 cannot be reported with 33880, 33881.
 Code 33886 can be reported only once, regardless of the number of modules deployed.
 To report radiological supervision and interpretation, report 75959 with 33886.
- **33889** **Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral**
 Code 33889 cannot be reported with 35694.
- **33891** **Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision**
 Code 33891 cannot be reported with 35509, 35601.

PULMONARY ARTERY

- 33910** **Pulmonary artery embolectomy; with cardiopulmonary bypass** [C] [50] [M]
 MED: 100-3, 240.6
- 33915** **without cardiopulmonary bypass** [C] [50] [M]
 MED: 100-3, 240.6
- 33916** **Pulmonary endarterectomy, with or without embolectomy, with cardiopulmonary bypass** [C] [50] [M]
 MED: 100-3, 240.6