2014 CPT/OPPS Update Part 1

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Objective

- Describe significant changes in CPT 2014
- Describe new codes
- Identify deleted codes
- Review revised codes and descriptors
- Identify new coding instructions and guidelines
- Supply AMA Errata and Technical Corrections available to date
- Procedure technique changes
- OPPS Final Rule

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Errata Correction

Front Matter

Introduction

Instructions for Use of the CPT Codebook (posted 11/11/13)

Throughout the CPT code set the use of terms such as "physician," "qualified health care professional," or "individual" is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency).

Revise the instructions for use of the CPT codebook guidelines to include missing content "define a service as limited to professionals or limited to other entities (eg, hospital or home health agency)."

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Evaluation and Management

2014 Final Rule Change for Clinic Visits

New Level II HCPCS code G0463 for Medicare Replaces the following Clinic Codes:

- 99201-99205
- 99211-99215

G0463 Hospital outpatient clinic visit

- SI= Q3
- APC= 0634
- National Allowed Amount $92.53

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Evaluation and Management

Hospital Inpatient Services

- 99238 Hospital Discharge Day Management: 30 min or less
- 99239; 31 min or more

(Parenthetical Revision Clarifies)

These codes are to be utilized to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient status. To report services to a patient who is admitted as an inpatient and discharged on the same date, see codes 99234-99236 for observation or inpatient hospital care including the admission and discharge of the patient on the same date. To report concurrent care services provided by an individual other then the physician or qualified health care professional performing the discharge day management service, use subsequent hospital care codes 99231-99233 on the date of discharge.

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Evaluation and Management

- New Subsection
- Guidelines
- **Interprofessional Telephone/Internet Consultations**
  - Non-Face to Face
- **New Codes**
  - 99446 Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified healthcare professional; 5-10 minutes of medical consultative discussion and review
  - 99447; 11-20 minutes
  - 99448; 21-30 minutes
  - 99449; 31 minutes or more

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Evaluation and Management

Interprofessional Telephone/Internet Consultations

- Includes:
  - Review of:
    - Records that are pertinent to the case
    - Laboratory and Imaging studies
    - Medication Profile
    - Pathology Specimens
- **Requirement**
  - **More than 50% of the time reported must be devoted to medical consultative verbal/internet discussion**
- **Coding Tip:** Do not report the consult code in addition

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Evaluation and Management

Interprofessional Telephone/Internet Consultations

- Documentation Requirements
  - Written or verbal request by treating physician or qualified healthcare professional
  - Reason for the consultation request
  - Verbal opinion report
  - A written report from the consulting physician to the treating physician or qualified healthcare professional

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Evaluation and Management

Interprofessional Telephone/Internet Consultations

Do not report when:

- There is immediate transfer of care to the consultant
- When there was or is going to be; a face to face visit with the consultant within the 14 day window
- When internet or telephone consults last less than 5 minutes
- The sole purpose of the call is to transfer the care

- **RULE:**
  - Codes can only be reported every 7 days

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Evaluation and Management

Pediatric Critical Care Patient Transport

Guideline Revisions

- 2012 list deleted by accident in the 2013 CPT manual
- Re-instated in the CPT 2014 Manual Page 42

New Codes: Inpatient Neonatal and Pediatric Critical Care

- Converted from CAT III 0260T-0261T to CAT I add-on codes
  - + 99481 Total body system hypothermia in a critically ill neonate per day
  - + 99482 Selective head hypothermia in a critically ill neonate per day

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Evaluation and Management

Guideline Changes

- Complex Chronic Care Coordination Services
  - Care Plan
  - Patient Population
  - Care coordination office/practice capabilities
  - Reporting requirements
- Transitional Care Management Services (TCM)
  - Applicability new patients
  - Clarify separately reported E/M Services
  - Specify discharge services that may not constitute the required face-to face visit
  - (TCM) is not reportable in the post-operative period of a service by the same individual who reported the operative service.

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Surgery

Integumentary System

- New Code
  - 10030 Image-guided fluid collection drainage by catheter soft tissue percutaneous
    - Established for reporting the bundled service of image-guided fluid collection drainage by catheter
    - Example: Fluids: abscess, hematoma, seroma, lymphocele, cyst
    - For percutaneous soft tissue
    - Example: Anatomic locations: abdominal wall, neck, extremities
- **Coding Tip**: Do not code with other imaging codes i.e., 75989, 76942, 77002, 77003, 77012, 77021
- New codes 49405-49407 are used for transvaginal/transrectal, visceral, peritoneal, or retroperitoneal collections

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Surgery

Integumentary System- Complex Repair (Closure)

Deleted Code

- 13150 Repair, complex eyelids, nose, ears and/or lips; 1.0 cm or less
  - 2014 for 1.0cm or less, see simple or intermediate repair

Revision

- 13151 Repair, complex, eyelids, nose, ears and/or lips; 1.1cm to 2.5cm
- 13152 2.6cm to 7.5cm
- + 13153 each additional 5cm or less

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Surgery

Integumentary System

Other Flaps and Grafts

Revision

- +15777 Implantation of biologic implant for soft tissue reinforcement (Breast and Trunk ONLY)

Coding Tip:

If bilateral breast procedure, report with modifier 50

If other than Breast or Trunk use CPT 17999

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Surgery

Breast Biopsy-Excision

Six new bundled codes

- 19081 Biopsy, breast, with placement of breast localization devices(s) eg, clip, metallic pellet, when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance
- +19082 ;each additional lesion, including stereotactic guidance

Guidelines: Significant language revisions to the introduction directing users to appropriate code sections.

- Example: Use 19100 and 19101 to report breast biopsies without imaging guidance

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Surgery

Breast Biopsy-Excision

Six new bundled codes

- 19083 & +19084; Ultrasound Guidance
- 19085 & +19086; Magnetic Resonance Guidance
  - New Parenthetical Instruction
  - New Guidelines: Specifically to direct users regarding codes for: Reporting of multiple biopsies or localization device placement using a different imaging modality
  - ***Remember*** Imaging of the biopsy specimen is bundled into these services when it is performed
    - Example: the physician uses radiography for a specimen from the patient, to make sure that the calcification is confirmed to be present in the specimen prior to sending it to the pathologist for analysis

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Breast Biopsy-Excision

What about open excision of breast lesions that do not require specific attention to adequate surgical margin resection?

- 19110-19126
  - Examples: Cysts, benign or malignant tumors

Coding Tip:

- Pre Op placement of markers may be included in procedure
  - Follow Guidelines, Parenthetical notes and code descriptions

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Surgery

Breast-Excision

New Guidelines

- 19301-19302 Partial Mastectomy
- 19303-19307 Total Mastectomy
  - Documentation "***MUST***" include attention to removal of adequate margins
- Excision of chest wall tumors including ribs 19260, 19271, 19272
  - Coding Tip: Guidelines indicate that these codes are not restricted to use with breast tumors

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Surgery

2014 price tag for 6 new bundled codes (OPPS)

CODE	Desc.	CI	SI	APC	Amount
19081	Bx breast 1st lesion strtctc	NI	T	0005	$702.08
+19082	Each addl lesion strctc	NI	N	N/A	$0.00
19083	Bx breast 1st lesion us imag	NI	T	0005	$702.08
+19084	Each addl lesion us imag	NI	N	N/A	$0.00
19085	Bx breast 1st lesion mr imag	NI	T	0005	$702.08
+19086	Each addl lesion mr imag	NI	N	N/A	$0.00

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Surgery

Breast Biopsy- Introduction

Eight new bundled codes

- 19281 Placement of breast localization device (s), (eg. Clip, metallic pellet, wire/needle, radioactive seeds), percutaneous: first lesion, including mammographic guidance
- + 19282; each additional lesion, including mammographic guidance
- 19283 & +19284; Stereotactic guidance
- 19285 & + 19286; Ultrasound guidance
- 19287 & + 19288; Magnetic resonance guidance

Deleted Codes

- 19290 Pre-Op placement of needle localization wire, Breast
- +19291; Each additional lesion
- +19295 Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration

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Surgery

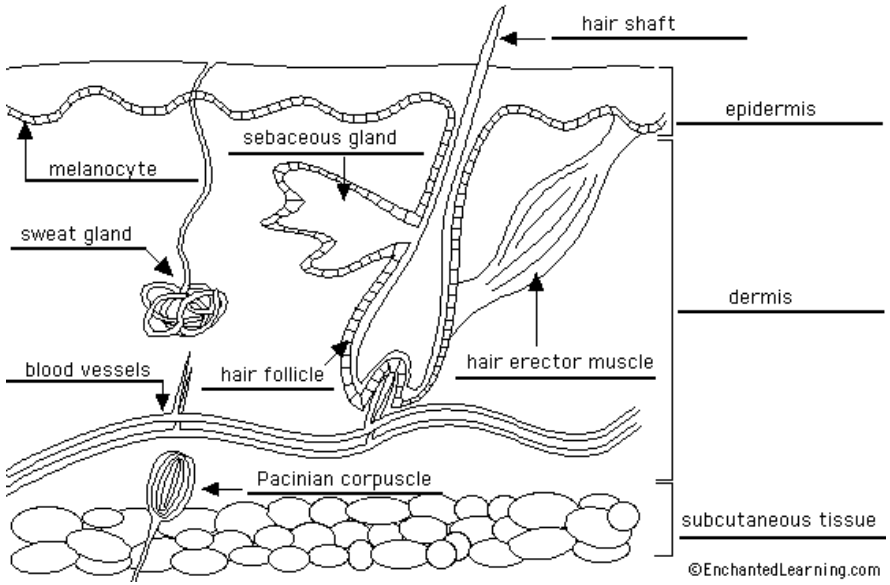
2014 price tag for 8 new bundled codes (OPPS)

CODE	Desc.	CI	SI	APC	Amount
19281	Perq device breast 1st imag	NI	Q2	0420	$98.25
+19282	Perq device breast add imag	NI	N	N/A	$ 0.00
19283	Perq dev breast 1st strtctc	NI	Q2	0420	$98.25
+19284	Perq dev breast add strtctc	NI	N	N/A	$ 0.00
19285	Perq dev breast 1st us imag	NI	Q2	0420	$98.25
+19286	Perq dev breast add us imag	NI	N	N/A	$ 0.00
19287	Perq dev breast 1st mr guide	NI	Q2	0420	$98.25
+19288	Perq dev breast add mr guide	NI	N	N/A	$ 0.00

Musculoskeletal System

Introductory Guideline Revisions

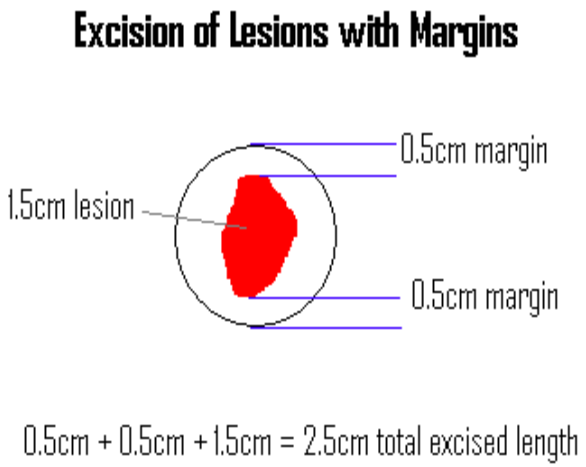
- Excision of subcutaneous soft connective tissue tumors
  - Include simple or intermediate repairs
  - Involves simple or marginal resection of tumors confined to subcutaneous tissue that is below the skin but above the deep fascia
  - Usually benign in nature



Musculoskeletal System

Introductory Guideline Revisions

- Excision of subcutaneous soft connective tissue tumors
  - Code selection based on location
  - Size of tumor
  - Measure greatest diameter of the tumor plus the margin required for complete excision
  - Measurement with margins at time of excision



Surgery

Musculoskeletal System

Introductory Guideline Revisions

- Radical resection of soft connective tissue tumors
  - Includes simple or intermediate repair
  - Involves resection of tumor with wide margins of normal tissue
  - Appreciable vessel exploration and /or neuroplasty repair or reconstruction
  - Most commonly used for malignant connective tissue tumors or very aggressive benign connective tissue tumors
  - Size and Location of Tumor
  - Diameter plus margins measured at the time of excision

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Surgery

Musculoskeletal System

Code Revisions

Sarcoma Definition:

a malignant tumor arising in tissue of mesodermal origin (as connective tissue, bone, cartilage, or striated muscle) that spreads by extension into neighboring tissue or by way of the bloodstream.

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Surgery

Musculoskeletal System

Code Revisions (Head)

- 21015 Radical resection of tumor (eg. Sarcoma), soft tissue of face or scalp; less than 2 cm
- 21016; 2 cm or greater
  - Radical resections of tumor (s) of cutaneous origin (eg. Melanoma) see 11620-11646

  Or

  - For excision of benign lesions of cutaneous origin (eg. Sebaceous cyst) see 11400-11406

Musculoskeletal System

Code Revisions (Neck)

- 21557 Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm
- 21558; 5 cm or greater

Back and Flank

- 21935 Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm
- 21936; 5 cm or greater

Abdomen

- 22904 Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; less than 5cm
- 22905; 5cm or greater

Musculoskeletal System

Code Revisions (Shoulder)

- 23077 Radical Resection of tumor (eg. Sarcoma), soft tissue of shoulder area; less than 5cm
- 23078; 5 cm or greater

Humerus (upper arm) and elbow

- 24077 Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm
- 24079; 5 cm or greater

Forearm and Wrist

- 25077 Radical resection of tumor (eg, sarcoma), soft tissue of forearm and /or wrist area; less than 3cm
- 25078; 3 cm or greater

Hand and Fingers

- 26117 Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; less than 3 cm
- 26118; 3 cm or greater

Musculoskeletal System

Code Revisions (Pelvis and Hip)

- 27049 radical resection of tumor (eg. Sarcoma), soft tissue of pelvis and hip area; less than 5 cm
- 27059; 5 cm or greater

Femur (Thigh Region) and Knee Joint

- 27329 Radical Resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm
- 27364; 5 cm or greater

Leg (Tia and Fibula) and Ankle Joint

- 27615 Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm
- 27616; 5 cm or greater

Foot and Toes

- 28046 Radical resection of tumor (eg, sarcoma) soft tissue of foot or toes; less than 3 cm
- 28047; 3 cm or greater

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Surgery

Musculoskeletal System (Introduction or Removal)

Shoulder Prosthesesis

Deleted Codes (Due to technique and technology changes)

- 23331 Removal of foreign body, shoulder; deep and
- 23332; Complicated

New Codes

- 23333 Removal of foreign body, shoulder; deep
  - For example: imbedded glass in subfascia or intramuscular

Surgery

Musculoskeletal System (Introduction or Removal)

Shoulder Prosthesesis *cont.*

New Codes

- 23334 Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component
- 23335; humeral and glenoid components
  - Example: Total shoulder
- Equipment:
  - Osteotomes
  - High speed Drill
  - Ultrasound

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Surgery

2014 price tag for 3 new codes (OPPS)

CODE	Desc.	CI	SI	APC	Amount
23333	Remove shoulder fb deep	NI	T	0020	$640.91
23334	Shoulder prosthesis removal	NI	T	0022	$1,736.53
23335	Shoulder prosthesis removal	NI	C	N/A	Inpatient Only

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Code Review

- 20680 Removal of implant; deep (eg. pin, screw, wire)
- 23330 Removal of subcutaneous foreign body, shoulder
- 23333 Removal of deep foreign body, shoulder
- 23334 Removal of one component of a shoulder arthroplasty
- 23335 Removal of both components of a shoulder arthroplasty

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Surgery

Musculoskeletal System (Introduction or Removal)

Code Revisions (Due to technique and technology changes)

- 24160 Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components
- 24164; radial head
  - Removal is more difficult with new technique
  - Components not cemented, current design includes metaphyseal fill, porous coated bone in growth makes removal difficult due to bone attaching to the stem
  - Special equipment is used to avoid bone loss, or fracture and allow complete removal of cement to avoid any infection
  - Work involved was potentially misvalued for new technique and technology

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Surgery

2014 Price tag for revised codes per OPPS vs. 2013

CODE	Year	CI	SI	APC	Amount
24160	2013	N/A	T	0050	$2, 306.77
24160	2014	CH	Q2	0050	$2,575.90
24164	2013	N/A	T	0050	$2, 306.77
24164	2014	CH	Q2	0050	$2,575.90

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Surgery

Musculoskeletal System (Introduction or Removal)

Coding Tip:

- Removal and replacement of a prosthesis is considered a revision.
- If removal of prosthesis is performed with treatment of an infection and the replacement occurs in a separate session a few weeks later, do NOT code as a revision

Surgery

Musculoskeletal System

Hip and Knee Arthroplasty

- 27130 Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
- 27446 Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
- 27447; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

Surgery

2014 Price tag for revised codes per OPPS vs. 2013

CODE	Year	CI	SI	APC	Amount
27446	2013	N/A	0425	T	$9, 601.88
27446	2014	N/A	0425	T	$9,732.07

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Musculoskeletal System (Fracture and/or Dislocation)

New Category III Code

- 0334T Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (eg. CT or fluoroscopic)
  - Bilateral procedures append modifier 50

Surgery

Respiratory System

Nose/Excision

Revised parenthetical note following CPT

- 30150 Rhinectomy; Partial
- 30160; total
  - For closure/and or reconstruction, primary or delayed, see Integumentary System, 13151-13160, 14060-14302, 15120, 15121, 15260, 15261, 15760, 20900-20912

Another revised parenthetical following CPT 30400

- For columellar reconstruction, see 13151 et seq

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Surgery

Respiratory System

Endoscopy Larynx

Revised Guidelines:

- For endoscopic procedures, report appropriate endoscopy of each anatomic site examined. Laryngoscopy includes:
  - examination of the tongue base
  - larynx
  - hypopharynx
- If using an operating microscope, telescope, or both, use the applicable code only once per operative session

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Surgery

Respiratory System

Incision

Deleted Code

- 32201 Pneumonostomy; with percutaneous drainage of abscess or cyst

New Parenthetical

- Use 49405 for percutaneous image-guided drainage of abscess or cyst of lungs or mediastinum by catheter placement

Surgery

Cardiovascular System

New Guidelines

- 33206-33249, 33262-33264
  - Includes skin pocket revision
  - I&D
    - See 10140, 10180, 11042, 11043, 11044, 11045, 11046, 11047 as appropriate

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Surgery

Cardiovascular System

Code Revisions and Guidelines

- 33222 Relocation of skin pocket for pacemaker
- 33223 Relocation of skin pocket for cardioverter-defibrillator

New Codes

- 0319T-0328T
  - Added to describe subcutaneous implantable defibrillator system that uses a subcutaneous pulse generator attached to a single subcutaneous electrode to treat ventricular tachyarrhythmias.

Surgery

Cardiovascular System

Patient- Activated Event Recorder

Code Revisions

- 33282 Implantation of patient-activated cardiac even recorder
- 33284 Removal of an implantable, patient-activated cardiac event recorder
  - Include moderate sedation as of CY 2014

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Surgery

Cardiovascular System

Cardiac Valves- TAVR/TAVI

- Deleted Code 0318T

New Code

- 33366 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg. Left thoracotomy)
- Codes that require two physicians working together
  - 33361, 33362, 33363, 33364, 33365, 33366
  - 33363, 33364, 33365 FDA approved September 2013

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Surgery

Cardiovascular System (Fenestrated Endovascular Repair of the Visceral and Infrarenal Aorta) (FEVAR)

New Codes

- 34841 Endovascular repair of visceral aorta by deployment of a fenestrated viscera aortic endograft and all associated radiological angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)
- 34842; including two visceral artery endoprostheses
- 34843; including three visceral artery endoprostheses
- 34844; including four or more visceral artery endoprostheses

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Surgery

Cardiovascular System (Fenestrated Endovascular Repair of the Visceral and Infrarenal Aorta) (FEVAR)

New Codes

- 34845 Endovascular repair of visceral aorta and infrarenal abdominal aorta with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one viscera artery endoprosthesis (superior mesenteric, celiac or renal artery)
- 34846; including two visceral artery endoprostheses
- 34847; including three visceral artery endoprostheses
- 34848; including four or more visceral artery endoprostheses

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Surgery

Cardiovascular System (Fenestrated Endovascular Repair of the Visceral and Infrarenal Aorta) (FEVAR)

Guidelines: 34841-34848

- Fenestrations allow for selective catheterization
  - Visceral and or/renal arteries and/
  - Subsequent placement of an endoprosthesis through an aortic endograft
- 34841-34844 report deployment of a fenestrated endoprosthesis spanning from the visceral aorta through the infrarenal aorta and does **not** enter or extend into the common iliac arteries
- 34845- 34848 **Does** enter or extend into the common iliac arteries

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What's included in 34841-34848?

- *Placement of unilateral or bilateral docking limbs (depending on the device)*
- *Any additional stent graft extensions that terminate in the aorta when codes 34841-34844 are performed or in the common iliac arteries when codes 34845-34848 are performed*
- *Proximal abdominal aortic extension prostheses*
- *Balloon angioplasty with in the target treatment zone of the endograft, either before or after endograft deployment*
- *Introduction of guide wires and catheters nonselective into the aorta and selective into the visceral and/or renal arteries*
- *Fluoroscopic guidance and radiological supervision and interpretation in conjunction with fenestrated endovascular aortic repair*

What's NOT included in 34841-34848?

- *Exposure of the access vessels (eg. 34812)*
- *Extensive repair of an artery (eg. 35226, 35286)*
- *Isolated endovascular infrarenal abdominal aortic aneurysm repair that does not require placement of a fenestrated graft to preserve flow to the visceral branch(es) (see 34800-34805)*
- *Interventional procedures performed at the time of fenestrated endovascular abdominal aortic aneurysm repair*
- *34825 or 34826 may be reported for distal extension prosthesis(es) that terminate in the internal iliac, external iliac, or common femoral artery(s)*
  - *May be reported separately!!*

Rationale for new Category I codes 34841-34848

Deleted Category III Codes:

- 0078T, 0079T, 0080T, 0081T
- Specific guidance regarding intended use and appropriate reporting instructions for new codes
- Clarification that RS&I is bundled into the new codes
- New parenthetical notes for the establishment of the new codes

Surgery

Cardiovascular System

Deleted Codes

- 37204
- 37205-27208
- 37210
  - New Parenthetical added to support the 4 newly established bundled codes 37241-37244
  - Transcatheter occlusion or embolization of the central nervous system 61624
  - Non central nervous system in the head and neck 61626
  - Inpatient only procedures

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Cardiovascular System

New Codes include moderate sedation

- 37241 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg. Congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)
- 37242; arterial, other than hemorrhage or tumor (congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)
- 37243; for tumors, organ ischemia, or infarction
- 37244; for arterial or venous hemorrhage or lymphatic extravasation

Cardiovascular System

What else is included in the new codes 37241-37244?

- All associated RS&I
- Intra-procedural guidance
- Road mapping
- Completion imaging

Guideline: Only 1 embolization code should be reported for each surgical field (ie, the area immediately surrounding and directly involved in a treatment/procedure)

Surgery

Cardiovascular System

What's NOT included in the new codes? 37241-37244

- Codes for catheter placement and diagnostic studies may be reported separately using the appropriate diagnostic angiography codes
- Apply Modifier 59 as appropriate
- More information and guidelines preceding CPT 75600 in the radiology section of CPT

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Surgery

2014 price tag for 4 new bundled codes (OPPS)

CODE	Desc.	CI	SI	APC	Amount
37241	Vasc embolize/occlude venous	NI	T	0082	$8,842.66
37242	Vasc embolize/occlude artery	NI	T	0082	$8,842.66
37243	Vasc embolize/occlude organ	NI	T	0082	$8,842.66
37244	Vasc embolize/occlude bleed	NI	T	0082	$8,842.66

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Surgery

Cardiovascular System

New Code

- 37217 Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation

Surgery

Cardiovascular System

- 37217 what's included:
  - Open vessel exposure
  - Vascular access closure
  - All access and selective catheterization of the vessel
  - Traversing the lesion
  - RS&I directly related to the intervention (when performed)
  - Standard closure of arteriotomy by suture
  - Imaging performed to document completion of the intervention in addition to the intervention(s) performed

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Cardiovascular System

Deleted Codes 37205-37208, 75960

New Codes

- 37236 Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including Radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery
- + 37237; each additional artery
- 37238 Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein
- + 37239; each additional vein

Surgery

Cardiovascular System

What's included in the new bundled codes 37236-37239?

- Balloon Angioplasty(s)
- Pre & Post dilation
- Treatment of lesion outside stented segment but in the same vessel, or use of larger or smaller balloon to achieve therapeutic results
- Radiologic Supervision and Interpretation directly related to intervention
- Closure arteriotomy by pressure, closure device or suture
- Completion Imaging

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Cardiovascular System

What's NOT included in the new bundled codes 37236-37239?

- Angioplasty in separate and distinct vessel(s)
- Non-selective and/or selective catheterizations
  - 36005, 36010-36015, 36200, 36215-36218, 36245-36248
- Extensive repair/replacement of artery 35226 or 35286
- Ultrasound guidance 76937 for vascular access, when performed in conjunction with 37236-37239
- Intravascular ultrasound 37250, 37251
- Mechanical thrombectomy and/or thrombolytic therapy 37184-37188, 37211-37214

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Surgery

2014 price tag for 4 new bundled codes (OPPS)

CODE	Desc.	CI	SI	APC	Amount
37236	Open/perq place stent 1st	NI	T	0229	$9, 119.70
+ 37237	Open/perq place stent ea add	NI	T	0083	$4,410.41
37238	Open/perq place stent same	NI	T	0229	$9, 119.70
+ 37239	Open/perq place stent ea add	NI	T	0083	$4,410.41

References

- American Medical Association Errata

http://www.ama-assn.org/resources/doc/cpt/cpt-corrections-errata-2014.pdf

- AMA CPT Changes Insiders View 2014
- CPT 2014 Professional Edition
- TAVR Studies: http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Transcatheter-ortic-Valve-Replacment-TAVR-.html
- TAVR National Coverage Determination: http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=257&
- OPPS Final Rule 2014

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Questions? Comments?

Thank you

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