Evaluation and Management Services:

**Eliminating “providers” and “physicians” from Evaluation and Management code descriptors**

Previous to the 2013 CPT Changes, Evaluation and Management codes had the following descriptions: “Counseling and/or coordination of care with providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.” This has now been changed to “Counseling and/or coordination of care with other physicians, qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.” This provides a more definitive description of what constitutes a “provider” from a CPT standpoint.

The previous verbiage was also followed by a time threshold with the following language, “Physicians typically spend (amount of time) face-to-face with the patient and/or family.” This has now been changed to “Typically (amount of time) are spent face-to-face with the patient and/or family.”

**Defining the broad term “Counseling”**

Counseling is now defined as: “a discussion with a patient and/or family concerning one or more of the following: Diagnostic results, impressions, and/or recommended diagnostic studies, Prognosis, Risks and benefits of management (treatment) options, Instructions for management (treatment) and/or follow-up, Importance of compliance with chosen management (treatment) option, Risk factor reduction, and Patient and family education”. Again, more definition provided at what may take place in a counseling session. A discussion with a patient in which treatment options, etc and the risks/benefits of those options, would fall under the counseling definition.

**Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services: Pediatric Critical Care Patient Transport**

Established to report non-face-to-face physician supervision of interfacility pediatric critical care transport, 24 months of age or younger.

For physician direction of emergency medical systems supervision for a pediatric patient older than 24 months of age, or at any age if not critically ill or injured, use 99288

Do not report 99485, 99486 with any other services reported by the control physician for the same period

Do not report 99485, 99486 in conjunction with 99466, 99467 when performed by the same physician

99485 Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes

99486 Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; each additional 30 minutes (list separately in addition to code for primary procedure)

**Complex Chronic Care Coordination Services:**

Codes 99487-99489 are reported once per calendar month; include all non-face-to-face CCCC services; include none or 1 face-to-face office or other outpatient, home, or domiciliary visit; and may only be reported by the single physician or other QHP who assumes the care coordination role with a particular patient for the calendar month.

Time of care coordination with the emergency department is reportable using 99487-99489, but time while the patient is inpatient or admitted as observation is not.
If the physician personally performs the clinical staff activities, his or her time may be counted toward the required clinical staff time to meet the elements of the code.

Additional E/M services beyond the first visit may be reported separately by the same physician or other QHP during the same calendar month.

99487 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

99488 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month

99489 Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

**Transitional Care Management Services:**
Codes 99495, 99496 require:—A face-to-face visit within the specified time frames;—Interactive contact with the patient or caregiver within 2 business days of discharge and may be direct (face-to-face), telephonic, or by electronic means;—Medication reconciliation and management no later than the date of the face-to-face visit

If another individual provides TCM services within the postoperative period of a surgical package, modifier 54 is not required.

The required contact with the patient or caregiver, as appropriate, may be by the physician or qualified health care professional or clinical staff. Within two business days of discharge is Monday through Friday except holidays without respect to normal practice hours or date of notification of discharge. The contact must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care. If two or more separate attempts are made in a timely manner, but are unsuccessful and other transitional care management criteria are met, the service may be reported.

99495 Transitional care management services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge

99496 Transitional care management services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period face-to-face visit, within 7 calendar days of discharge

**Physician Documentation of Face-to-Face visit for Durable Medical Equipment (DME)**
G0454 Physician documentation of face-to-face visit for Durable Medical Equipment determination performed by Nurse Practitioner, Physician Assistant or Clinical Nurse Specialist

**Musculoskeletal System:**
Orthopedic-specific surgical CPT code changes
Guidelines have been revised in the following areas:

**Spine CPT Errata**—Changes formalized for 2013. A guideline change has been added to the spine bone grafts (20930–20938), instrumentation (22840–22844, 22848, 22845–22847), and intervertebral device (22851) CPT codes. The change supports a CPT Errata issued in May 2012 that addressed the omission of CPT codes 22633 and
2013 CPT Changes – All Specialties

22634 as appropriate primary or index codes for bone graft, instrumentation, and intervertebral device codes. These codes may be appropriately related.

**Bone marrow aspirate**—Clarification has been added following the bone graft codes (20930–20938) related to bone marrow aspiration. CPT code 38220 defines the work associated with the harvest of bone marrow for bone grafting; it should not be used to report bone marrow aspirate for platelet-rich stem cells. Instead, Category III code 0232T should be used when bone marrow aspiration is performed for platelet-rich stem cell.

**Cervical Spinal Arthrodesis Guideline**—Guidelines were added to CPT codes 22554, 22585, 63075, and 63076; if the work associated with these procedures is performed during the same surgery by the same surgeon or by two separate surgeons/individuals during the same session, the correct codes are 22551 and 22552. CPT codes 63075 and 22554 may not be unbundled and reported for the same patient, same session.

**Cast application**—Guideline changes were made in the “Application and Strapping” section addressing the application of the first cast, its removal, coding by the individual who performs the initial service, and restorative management. Refer to the section for specific comments. CPT code 29590 (Denis-Browne bar [splint] with manipulation and casting [eg, for metatarsus adductus, clubfoot]) was deleted.

**Hip arthroscopy**—Under a new guideline instruction, CPT code 29916 (Arthroscopic labral repair of a torn labrum) is considered inherent to CPT codes 29915, 29862, and 29863. CPT code 29916 should not be reported in addition to CPT codes 29915, 29862, or 29863 because the repair is already included in these codes, whether as a takedown and repair or a repair of an already torn labrum. This guideline is not new information, but a clarification based on inquiries received since the introduction of the new hip arthroscopy codes.

**Chemodenervation**—A guideline change was introduced for CPT code 64614 (Chemodenervation of muscle(s); extremity and/or trunk muscle(s) [eg, for dystonia, cerebral palsy, multiple sclerosis]). CPT code 64614 may only be reported once per extremity. The parenthetical (s) was removed from extremity. A parenthetical instruction following CPT code 64614 states that modifier 50 should not be appended to this code. Check with your payers to determine specific rules to code submission.

**Intraoperative nerve monitoring**—Clarification was added in the Intraoperative Neurophysiology section. Intraoperative nerve monitoring by the operating surgeon is included in the primary surgical service and is not separately reportable. This is a clarification—not a new instruction.

22586 Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace

0309T Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft, when performed, lumbar, L4-L5 interspace. This is a category III code and is an add-on code to 22586.

23473 Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component

23474 Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component

24370 Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component

24371 Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component
Respiratory System:
- 32420 has been deleted. To report, use 32405
- 32421 and 32422 have been deleted. To report, see 32554, 32555
- The new codes in the respiratory system for pleural drainage, additional specific bronchoscopy codes and new codes for thoracentesis, which now have codes to differentiate whether imaging guidance was used.
  - Do not report 32503, 32504 in conjunction with 19260, 19271, 19272, 32100, 32551, 32554, 32555
  - For insertion of indwelling tunneled pleural catheter with cuff, use 32550
  - For open procedure, use 32551
    - Note: This is a REAL CHEST TUBE
  - Do not report 32554-32557 in conjunction with 32550, 32551, 76942, 77002, 77012, 77021, 75989

31647 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe

31648 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe

31649 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (list separately in addition to code for primary procedure)

31651 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (list separately in addition to code for primary procedure[s])

31660 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe

31661 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes

32554 Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance

32555 Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance

32556 Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance

32557 Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance

32701 Thorax stereo rad target w/tx
  - Do not report 32701 in conjunction with 77261-77799
  - For placement of fiducial markers, see 31626, 32553

Cardiovascular System:
Codes 33361-33365, 0318T are used to report transcatheter aortic valve replacement (TAVR)/transcatheter aortic valve implantation (TAVI). TAVR/TAVI requires two physician operators and all components of the procedure are reported using modifier 62.

Codes 33361-33365, 0318T include the work, when performed, of percutaneous access, placing the access sheath, balloon aortic valvuloplasty, advancing the valve delivery system into position, repositioning the valve as needed,
deploying the valve, temporary pacemaker insertion for rapid pacing (33210), and closure of the arteriotomy when performed. Codes 33361-33365, 0318T include open arterial or cardiac approach.

Angiography, radiological supervision, and interpretation performed to guide TAVR/TAVI (eg, guiding valve placement, documenting completion of the intervention, assessing the vascular access site for closure) are included in these codes.

Diagnostic left heart catheterization codes (93452, 93453, 93458-93461) and the supravalvular aortography code (93567) should not be used with TAVR/TAVI services (33361-33365, 0318T) to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TAVR/TAVI
2. Aorta/left ventricular outflow tract measurement for the TAVR/TAVI, or
3. Post-TAVR/TAVI aortic or left ventricular angiography, as this work is captured in the TAVR/TAVI services codes (33361-33365, 0318T).

Diagnostic coronary angiography performed at the time of TAVR/TAVI may be separately reportable if:
No prior catheter-based coronary angiography study is available and a full diagnostic study is performed, or
A prior study is available, but as documented in the medical record:

a. The patient’s condition with respect to the clinical indication has changed since the prior study, or
b. There is inadequate visualization of the anatomy and/or pathology, or
c. There is a clinical change during the procedure that requires new evaluation.
d. For same session/same day diagnostic coronary angiography services, report the appropriate diagnostic cardiac catheterization code(s) appended with modifier 59 indicating separate and distinct procedural service from TAVR/TAVI.

Diagnostic coronary angiography performed at a separate session from an interventional procedure may be separately reportable.

Other cardiac catheterization services are reported separately when performed for diagnostic purposes not intrinsic to TAVR/TAVI.

When transcatheter ventricular support is required in conjunction with TAVR/TAVI, the appropriate code should be reported with the appropriate ventricular assist device (VAD) procedure code (33990-33993, 33975, 33976, 33999) or balloon pump insertion code (33967, 33970, 33973).

The TAVR/TAVI cardiovascular access and delivery procedures are reported with 33361-33365, 0318T. When cardiopulmonary bypass is performed in conjunction with TAVR/TAVI, codes 33361-33365, 0318T should be reported with the appropriate add-on code for percutaneous peripheral bypass (33367), open peripheral bypass (33368), or central bypass (33369).

Procurement of the saphenous vein graft is included in the description of the work for 33510-33516 and should not be reported as a separate service or co-surgery. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs graft procurement, add modifier 80 to 33510-33516. For percutaneous ventricular assist device insertion, removal, repositioning, see 33990-33993.

Procurement of the saphenous vein graft is included in the description of the work for 33517-33523 and should not be reported as a separate service or co-surgery. Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery,
use 35600 in addition to the bypass procedure. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier 80 to 33517-33523, 33533-33536, as appropriate. For percutaneous ventricular assist device insertion, removal, repositioning, see 33990-33993.

Procurement of the artery for grafting is included in the description of the work for 33533-33536 and should not be reported as a separate service or co-surgery, except when an upper extremity artery (eg, radial artery) is procured. To report harvesting of an upper extremity artery, use 35600 in addition to the bypass procedure. To report harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure. To report harvesting of a femoropopliteal vein segment, report 35572 in addition to the bypass procedure. When surgical assistant performs arterial and/or venous graft procurement, add modifier 80 to 33517-33523, 33533-33536, as appropriate. For percutaneous ventricular assist device insertion, removal, repositioning, see 33990-33993.

Patients receiving major cardiac procedures may require simultaneous cardiopulmonary bypass insertion of cannulae into the venous and arterial vasculatures with support of circulation and oxygenation by a heart-lung machine. Most services are described by codes in dyad arrangements to allow distinct reporting of procedures with or without cardiopulmonary bypass. Cardiopulmonary bypass is distinct from support of cardiac output using devices (eg, ventricular assist or intra-aortic balloon). For cardiac assist services see 33960-33983, 339XX1-33993.

The insertion of a ventricular assist device (VAD) can be performed via percutaneous (33990, 33991) or transthoracic (33975, 33976, 33979) approach. The location of the ventricular assist device may be intracorporeal or extracorporeal.

For surgical insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO), use 36822.

Open arterial exposure when necessary to facilitate percutaneous ventricular assist device insertion (33990, 33991), may be reported separately (34812). Extensive repair or replacement of an artery may be additionally reported (eg, 35226 or 35286).

Removal of a ventricular assist device (33977, 33978, 33980, 33992) includes removal of the entire device, including the cannulas. Removal of a percutaneous ventricular assist device at the same session as insertion is not separately reportable. For removal of a percutaneous ventricular assist device at a separate and distinct session, but on the same day as insertion, report 33992 appended with modifier 59 indicating a distinct procedural service.

Repositioning of a percutaneous ventricular assist device at the same session as insertion is not separately reportable. Repositioning of percutaneous ventricular assist device not necessitating imaging guidance is not a reportable service. For repositioning of a percutaneous ventricular assist device necessitating imaging guidance at a separate and distinct session, but on the same day as insertion, report 33993 with modifier 59 indicating a distinct procedural service.

Replacement of the entire implantable ventricular assist device system, ie, pump(s) and cannulas, is reported using the insertion codes (ie, 33975, 33976, 33979). Removal (ie, 33977, 33978, 33980) of the ventricular assist device system being replaced is not separately reported. Replacement of a percutaneous ventricular assist device is reported using implantation codes (ie, 33990, 33991). Removal (ie, 33992) is not reported separately.

33361 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach

33362 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach
Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach

Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach

Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (e.g., median sternotomy, mediastinotomy)

Replace aortic valve w/byp

Replace aortic valve w/byp

Replace aortic valve w/byp

Insert vad artery access

Insert vad art&vein access

Remove vad different session

Reposition vad diff session

Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed
Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)

Place cath intracranial art

Remove intrvas foreign body

Thrombolytic art therapy

Thrombolytic venous therapy

Thromblytic art/ven therapy

Cessj therapy cath removal

**Medicine – Cardiovascular: Ablation Code Guidelines**

Deletion of intracardiac catheter ablation codes 93651 and 93652

5 new codes (93653-93657) differentiating ablation techniques for:

– Supraventricular arrhythmias

– Ventricular arrhythmias

– Pulmonary vein isolation (for atrial fibrillation)

– Ablation of discrete mechanism of arrhythmia separate from the primary ablated mechanism

– Additional linear or focal ablation for mechanism of atrial fibrillation remaining after pulmonary vein isolation

Ablation codes (93653-93657) include the single site and comprehensive electrophysiology study services (93600-03603, 93619, 93620)

Atrial fibrillation ablation (93656) includes pacing and recording from the coronary sinus (93621) when performed.

Trans-septal puncture (93462) may be reported separately for ablations except for atrial fibrillation ablation (93656, 93657) which includes trans-septal puncture

93653, 93654, and 93656 are distinct primary services and may not be reported together

Mapping is a distinct procedure and may be reported separately with atrial ablation procedures

VT ablation (93654) includes mapping

Do not report standard mapping (93609) in addition to 3-D mapping (93613)—only one or the other
Which add-on code (93655 or 93657) should be reported if a successful pulmonary vein isolation procedure for atrial fibrillation reveals a second, independent mechanism?

- Report +93655 when an additional non-atrial fibrillation tachycardia mechanism is identified after atrial fib ablation
- Report +93657 when an additional left or right atrial focus for atrial fibrillation is identified after successful pulmonary vein isolation

**PCI Guidelines**

For PCI services, definition of “major” vessel now includes LAD, left circumflex, and right coronary plus left main and ramus intermedius

All interventions in a major vessel itself (including proximal, mid, and distal vessel) are reported with one PCI code (report the highest service level of intervention performed)

Interventions in up to 2 branches of each major vessel may be reported with add-on codes (LAD diagonals, circumflex marginals, etc.)

---

**Reporting Guidelines for Multiple Target Lesion Procedures—Base Codes**

Report only one base code for each major coronary artery approached (LAD, CFX, RCA, LM, ramus intermedius); that code reports all services in that major vessel (prox, mid, distal)

Report, as the base code, the most intensive service performed in that major vessel system

1. Acute total occlusion = chronic total occlusion higher than
2. Atherectomy + stent higher than
3. Atherectomy without stent higher than
4. Stent higher than
5. Any service through a bypass graft higher than
6. Balloon angioplasty alone (based upon CMS valuations)

**Reporting Guidelines for Multiple Target Lesion Procedures—Add-on Codes**

Report up to 2 add-on codes for services in branches of each major coronary artery approached; that code reports all services in that branch (prox, mid, distal)

Services performed in more than 2 branches are not separately reportable.

Report, as add-on code, the most intensive service(s) performed in that major vessel system

1. Chronic total occlusion = bypass graft service higher than
2. Atherectomy with stent higher than
3. Atherectomy without stent higher than
4. Stent higher than
5. Balloon angioplasty alone (based upon RUC valuations)

If a single lesion extends from one target vessel (major coronary artery, graft, or branch) into another target vessel but can be revascularized with a single intervention bridging the two vessels, report with a single code (eg, LAD into diagonal, LM into LAD)

For bifurcation lesions (when both treated), report for both vessels (eg, LAD and LAD diagonal)
Guidelines for Services Performed On or Through Bypass Grafts

Describes arterial and venous conduits, both direct (eg, LIMA) and free (eg, RIMA from aorta to RCA)

Each separate graft represents a major coronary artery

A sequential graft (more than one distal anastomosis) represents only one graft

A branching graft (Y graft) represents a major vessel for the main graft (aorta to distal anastomosis) and each branch off the main graft represents an additional coronary vessel

PCI performed on a major vessel through a graft is reported using the graft PCI codes

When a major artery is treated both through the native circulation and through a graft, report both base codes

Reporting Diagnostic Angiography when Performed at Time of Intervention

No prior catheter-based coronary angiography is available and a full diagnostic study is performed and decision to intervene is based upon the results OR

A prior study is available but, as documented in the medical record, either:

– The patient’s clinical condition (relating to the indication) has changed since the prior study; or
– Inadequate visualization of the anatomy in the prior study; or
– Clinical change during the procedure requiring new evaluation outside of the target area of PCI

New Cardiac Catheterization Guidelines

Do not report pharmacologic administration +93463 in conjunction with PCI (92920-92944) or with coronary thrombolysis (92975, 92977)

Injection for pulmonary angiography (+93568) may be reported with right heart catheterization codes 93451, 93453, 93456, 93457, 93460-93461, 93530-93533

When aortography is performed with other cardiac catheterization procedures, report +93567 for supravalvular aortography and the radiological supervision and interpretation code (36221, 75600-75630) for non-supravalvular thoracic or abdominal aortography

92920 Percutaneous transluminal coronary angioplasty; single major coronary artery or branch

92921 Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)

92924 Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch

92925 Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)

92928 Percutaneous transcatheater placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch

92929 Percutaneous transcatheater placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)
2013 CPT Changes – All Specialties

92933 Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch

92934 Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)

92937 Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel

92938 Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)

92941 Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel

92943 Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel

92944 Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)

93653 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, his recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry

93654 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, his recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3d mapping, when performed, and left ventricular pacing and recording, when performed

93655 Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (list separately in addition to code for primary procedure)

93656 Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, his bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation

93657 Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial
fibrillation remaining after completion of pulmonary vein isolation (list separately in addition to code for primary procedure)

**Hemic & Lymphatic Systems:**
38243 Hematopoietic progenitor cell (hpc); hpc boost

**Digestive System:**
One Deleted Code – 43234. To report, use 43235

New Category III Codes for Laparoscopic Implantation, Vagus Nerve Blocking Therapy for Morbid Obesity
0312T, 0313T, 0314T, 0315T, 0316T, 0317T

43206 Esoph optical endomicroscopy

43252 Upper GI optical endomicroscopy

44705 Preparation of fecal microbiota for instillation, including assessment of donor specimen

G0455 Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen

**Urinary System:**
52287 Cystourethroscopy with injection(s) for chemodenervation of the bladder

**Nervous System:**
64615 Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)

**Radiology - Nuclear Medicine:**
78012 Thyroid uptake measurement

78013 Thyroid imaging w/blood flow

78014 Thyroid imaging w/blood flow

78071 Parathyrd planar w/wo subtrj

78072 Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization

**Pathology & Laboratory:**
G0452 Molecular pathology procedure; physician interpretation and report

HCPCS code G0452 is used for professional component-only and will be considered a “clinical laboratory interpretation service”. HCPCS code G0452 will replace the CPT code that is used for interpretation and report of a molecular pathology test (CPT code 83912-26).
86152 Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood)

86153 Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required

CPT codes 86152 and 86153 replaces CPT Category III codes 0279T and 0280T

88375 Optical endomicroscopy interp

**Medicine – Gastroenterology:**

91112 Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report

**Medicine - Allergy & Clinical Immunology:**

95017 Perq & icut allg test venoms

95018 Perq&ic allg test drugs/biol

95076 Ingest challenge ini 120 min

95079 Ingest challenge addl 60 min

**Medicine - Sleep Studies:**

95782 Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

95783 Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist

**Medicine - Neurology & Neuromuscular Procedures:**

95907 Nerve conduction studies; 1-2 studies

95908 Nerve conduction studies; 3-4 studies

95909 Nerve conduction studies; 5-6 studies

95910 Nerve conduction studies; 7-8 studies

95911 Nerve conduction studies; 9-10 studies

95912 Nerve conduction studies; 11-12 studies
2013 CPT Changes – All Specialties

95913 Nerve conduction studies; 13 or more studies

95924 Ans parasymp & symp w/tilt

95940 Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes

95941 Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour

G0453 Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)

95943 Parasymp&symp hrt rate test

Physical Medicine and Rehabilitation: Active Wound Care Management:

G0456 Negative pressure wound therapy, (eg vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

G0457 Negative pressure wound therapy, (eg vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 sq cm