



CORRECTIONS DOCUMENT—CPT® 2009

Front Matter Modifiers (See Appendix A for Definitions)

22 ~~Unusual~~**Increased** procedural services

Correct the description for consistency with the primary listing in Appendix A.

Anesthesia Other Procedures

01992 *Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position*

Do not report code 01991 or 01992 in conjunction with 99143-99150)

(When regional intravenous administration of local anesthetic agent or other medication in the upper or lower extremity is used as the anesthetic for a surgical procedure, report the appropriate anesthesia code. To report a Bier block for pain management, use 64999. ~~For intra-arterial or intravenous injections, see 90773, 90774)~~

(For intra-arterial or intravenous therapy for pain management, see 96373, 96374)

Revise parenthetical note following 01992 referencing deleted codes 90773, 90774.

Evaluation and Management

Newborn Care Services

Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services

Inpatient Neonatal and Pediatric Critical Care

The same definitions for critical care services apply for the adult, child, and neonate.

Codes 99468, 99469 are used to report services provided by a physician directing the inpatient care of a critically ill neonate or infant 28 days of age or less. They represent care starting with the date of admission (99468) and subsequent day(s) (99469) that the neonate remains critical. These codes may be reported only by a single physician and only once per day, per patient.

The initial day neonatal critical care code (99468) can be used in addition to 99464 or 99465 as appropriate, when the physician is present for the delivery (99464) or resuscitation (99465) is required. Other procedures performed as a necessary part of the resuscitation (eg, endotracheal intubation [31500]) are also reported separately when performed as part of the pre-admission delivery room care. In order to report these procedures separately, they must be performed as a necessary component of the resuscitation and not simply as a convenience before admission to the neonatal intensive care unit.

Codes 99471-99476 are used to report services provided by a physician directing the inpatient care of a critically ill infant or young child from 29 days of postnatal age through 5 years of age. They represent care starting with the date of admission (99471, 99475) and subsequent day(s) (99472, 99476) the infant or child remains critical. These codes may be reported only by a single physician and only once per day, per patient in a given setting. Service for the critically ill or critically injured child older than 5 years of age would be reported with critical care codes (99291, 99292).



The pediatric and neonatal critical care codes include those procedures listed for the critical care codes (99291, 99292). In addition, the following procedures are also included (and not separately reported) in the pediatric and neonatal critical care service codes (99468-99472, 99475, 99476), the intensive care services codes (99477-99480), and the pediatric critical care patient transport codes (99466, 99467):

Vascular access procedures

Peripheral vessel catheterization (36000)

Other arterial catheters (36140, 36620)

Umbilical venous catheters (36510)

Central vessel catheterization (36555)

Vascular access procedures (36400, 36405, 36406)

Vascular punctures oral (36420, 36600)

Umbilical arterial catheters (36660)

Delete the word “oral” from the list of included procedures for the Inpatient Neonatal and Pediatric Critical Care guideline section 99468-99476.

Evaluation and Management

Newborn Care Services

Delivery/Birthing Room Attendance and Resuscitation Services

- 99465 Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output
(Do not report 99465 may be reported in conjunction with 99460, 99468, 99477)

Revise parenthetical note following 99465 to instruct that the listed services are appropriately reported in addition to 99465.

Surgery

Digestive System

Stomach

Laparoscopy

43647 *Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum*

43648 *revision or removal gastric neurostimulator electrodes, antrum*

(For open approach, see 43881, 43882)

(For electronic analysis and programming of gastric neurostimulator, ~~lesser curvature,~~ use Category III code 0162T see 95980-95982)

Revise parenthetical note following 43648 referencing deleted Category III code 0162T and replace with 95980-95982.



Surgery
Nervous System
Spine and Spinal Cord
Injection, Drainage, or Application

- 62267 Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes
(For imaging, see 77003, ~~77042~~)
(Do not report 62267 in conjunction with 10022, 20225, 62287, 62290, 62291)

Delete the CT guidance code 77012 from parenthetical note following 62267.

Radiology
Nuclear Medicine
Therapeutic

- 79101 Radiopharmaceutical therapy, by intravenous administration

(Do not report 79101 in conjunction with 36400, 36410, 79403, ~~90760-96360~~, ~~90774~~ ~~96374~~ or ~~90775~~ ~~96375~~, 96409)

(For radiolabeled monoclonal antibody by intravenous infusion, use 79403)

(For infusion or instillation of non-antibody radioelement solution that includes 3 months follow-up care, use 77750)

Revise parenthetical note following 79101 referencing deleted codes 90760, 90774, 90775 and replace with 96930, 96374, 96375.

Radiology
Clinical Brachytherapy

- (77781 has been deleted. To report, see 77785, 77786)
 - (77782-77784 have been deleted. To report, see 77785-77787)
 - 77785 Remote afterloading high dose rate radionuclide brachytherapy; 1 channel
 - 77786 2-12 channels
 - 77787 over 12 channels
- (Do not report ~~77785-77787~~ in conjunction with Category III code 0182T)

Add parenthetical note following 77787 to exclude the reporting of 77785-77787 in conjunction with 0182T.

**Radiology
Nuclear Medicine
Therapeutic**

79445 *Radiopharmaceutical therapy, by intra-arterial particulate administration*

(Do not report 79445 in conjunction with ~~90773~~ 96373, 96420)

(Use appropriate procedural and radiological supervision and interpretation codes for the angiographic and interventional procedures provided prerequisite to intra-arterial radiopharmaceutical therapy)

Revise parenthetical note following 79445 referencing deleted code 90773 and replace with 96373.

**Pathology and Laboratory
Microbiology**

87802 *Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group B*

▲ 87810 ~~Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis~~

▲ 87850 Neisseria gonorrhoeae

▲ 87880 Streptococcus, group A

▲ 87899 not otherwise specified

Add revision symbol (▲) to codes 87850, 87880, and 87899. The descriptors for these codes were also revised to reflect the inclusion of antigen as in code 87810 and the parent code 87802.

**Pathology and Laboratory
Reproductive Medicine Procedures**

89335 *Cryopreservation, reproductive tissue, testicular*

(For cryopreservation of embryo(s), use 89258. For cryopreservation of sperm, use 89259)

~~*(For cryopreservation of reproductive tissue, ovarian, use Category III code 0058T)*~~

~~*(For cryopreservation of oocyte, use Category III code 0059T)*~~

(For cryopreservation, ovarian reproductive tissue, oocytes, use 89240)

Delete parenthetical notes that refer to deleted codes 0058T, 0059T, and replace with a new parenthetical note to instruct the appropriate reporting for this service with 89240.



**Medicine
Cardiovascular
Therapeutic Services and Procedures**

Ⓞ +92974 *Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)*

(Use 92974 in conjunction with 92980, 92982, 92995, 93508)

(For intravascular radioelement application, see ~~77781-77784~~ 77785-77787)

Revise parenthetical note following 92974 referencing deleted codes 77781-77784 and replace with 77785-77787.

**Medicine
Cardiovascular
Therapeutic Services and Procedures**

Ⓞ 92980 *Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel*

Ⓞ +92981 *each additional vessel (List separately in addition to code for primary procedure)*

(Use 92981 in conjunction with 92980)

(Codes 92980, 92981 are used to report coronary artery stenting. Coronary angioplasty [92982, 92984] or atherectomy [92995, 92996], in the same artery, is considered part of the stenting procedure and is not reported separately. Codes 92973 [percutaneous transluminal coronary thrombectomy], 92974 [coronary brachytherapy] and 92978, 92979 [intravascular ultrasound] are add-on codes for reporting procedures performed in addition to coronary stenting, atherectomy, and angioplasty and are not included in the "therapeutic interventions" in 92980)

(To report additional vessels treated by angioplasty or atherectomy only during the same session, see 92984, 92996)

(To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use 92974)

(For intravascular radioelement application, see ~~77781-77784~~ 77785-77787)

Ⓞ 92982 *Percutaneous transluminal coronary balloon angioplasty; single vessel*

Ⓞ +92984 *each additional vessel (List separately in addition to code for primary procedure)*

(Use 92984 in conjunction with 92980, 92982, 92995)

(For stent placement following completion of angioplasty or atherectomy, see 92980, 92981)



(To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use 92974)

(For intravascular radioelement application, see ~~77781-77784~~ 77785-77787)

Revise parenthetical notes following 92981, 92984 referencing deleted codes 77781-77784 and replace with 77785-77787.

Medicine
Medicine
Cardiovascular
Cardiovascular Device Monitoring—Implantable and Wearable Devices

~~Cardiovascular monitoring services are ...~~
~~ECG rhythm derived elements are distinct...~~
~~For monitoring...~~
~~Transtelephonic rhythm strip...~~
~~93279 — Programming device evaluation...~~

Strike through “and Wearable” to delete this from the subheading.

Medicine
Cardiovascular
Cardiovascular Device Monitoring—Implantable and Wearable Devices

Cardiovascular monitoring services...
A service center may report...
ECG rhythm derived elements are ...
For monitoring by wearable devices, see 93224-93272, ~~93228, 93229~~.

Delete 93228, 93229 from guidelines. Codes 93228 and 93229 are already included in the code range 93224-93272, and therefore should not be listed separately.

Medicine
Cardiovascular
Cardiovascular Device Monitoring—Implantable and Wearable Devices

Cardiovascular monitoring services are diagnostic medical procedures.....
Implantable cardioverter-defibrillator (ICD): an implantable device that provides ...
Implantable loop recorder (ILR): an implantable device that continuously records ...
Interrogation device evaluation (in person): an face-to-face evaluation of an implantable device such as a cardiac pacemaker, implantable cardioverter-defibrillator, implantable cardiovascular monitor, or implantable loop recorder. Using an office, hospital, or emergency room instrument, stored and measured information about the lead(s) when present, sensor(s) when present, battery and the implanted pulse generator function, as well as data collected about the patient’s heart rhythm and heart rate is retrieved. The retrieved information is evaluated to determine the current programming of the device and to evaluate certain aspects



of the device function such as battery voltage, lead impedance, tachycardia detection settings, and rhythm treatment settings.

Delete “in person” and “face-to-face” language from the Interrogation device evaluation guidelines to eliminate descriptions that conflict with the intent of the interrogation device guidelines for in-person and remote interrogations.

Medicine

Cardiovascular

Cardiovascular Device Monitoring—Implantable and Wearable Devices

Cardiovascular monitoring services...

A service center may report 93296 or 93299 during a period in which a physician performs an in-person interrogation device evaluation. A physician may not report an in-person and remote interrogation of the same device during the same period. Report only remote services when an in-person interrogation device evaluation is performed during a period of remote interrogation device evaluation. A period is established by the initiation of the remote monitoring or the 91st day of a pacemaker or implantable cardioverter-defibrillator (ICD) monitoring or the 31st day of an implantable loop recorder (ILR) or implantable cardiovascular monitor (ICM) monitoring and extends for the subsequent ~~30~~ **90** or ~~90~~ **30** days, respectively, for which remote monitoring is occurring. Programming device evaluations and in-person interrogation device evaluations may not be reported on the same date by the same physician. Programming device evaluations and remote interrogation device evaluations may both be reported during the remote interrogation device evaluation period.

ECG rhythm derived elements are ...

Correct “subsequent 30 or 90 days” to reflect the correct respective order of the preceding instructions in the Cardiovascular Device Monitoring guidelines.

Medicine

Cardiovascular

Cardiovascular Device Monitoring—Implantable and Wearable Devices

●93279 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system

●93285 implantable loop recorder system

(Do not report 93285 in conjunction with 33282, 93279, -93284, 93291)

Strike through the comma and add a hyphen between 93279-93284 to reflect a sequence of codes in the parenthetical note following 93285.



Medicine

Cardiovascular

Cardiovascular Device Monitoring—Implantable and Wearable Devices

●93297 Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s)

●93298 implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s)

(Do not report 93298 in conjunction with 33282, 93291, 93297)

(Report 93298 only once per 30 days)

Add code 33282 to the parenthetical note following 93298.

Medicine

Cardiovascular

Cardiac Catheterization

◻93508 *Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization*

(93508 is to be used only when left heart catheterization 93510, 93511, 93524, 93526 is not performed)

(93508 is to be used only once per procedure)

(To report transcatheter placement of radiation delivery device for coronary intravascular brachytherapy, use 92974)

(For intravascular radioelement application, see ~~77781-77784~~ 77785-77787)

Revise parenthetical note following 93508 referencing deleted codes 77781-77784 and replace with 77785-77787.

Medicine

Neurology and Neuromuscular Procedures

Sleep Testing

Sleep studies and polysomnography refer to the continuous and simultaneous...

The sleep services (95895-95811) include recording, interpretation and report...

For a study to be reported as polysomnography, sleep must be reported and staged.

(Report with modifier 52 if less than 6 hours of recording or in other cases of reduced services as appropriate)

(For unattended sleep study, use 95806)

●95803 Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)

(Do not report 95803 more than once in any 14 day period)



(Do not report 95803 in conjunction with 95806-95811)

(Report with modifier 52 if less than 6 hours of recording or in other cases of reduced services as appropriate)

(For unattended sleep study, use 95806)

Moved two parenthetical notes following 95803 to its conventional place following the Sleep Testing guidelines to reflect the entire range of codes.

Category III

0182T High dose rate electronic brachytherapy, per fraction

(Do not report 0182T in conjunction with 77761-77763, 77776-77778, 77781-77784, 77785-77787, 77789)

Revise parenthetical note following 0182T referencing deleted codes 77781-77784 and replace with 77785-77787.

Appendix B
Summary of Additions,
Deletion, and Revisions

35632 Code added

Add code 35632 to Appendix B to reflect new code added for 2009.

Appendix K
Product Pending FDA Approval

90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use

Remove 90696 from Appendix K, as this code received FDA approval.

Index
Implantation
Mesh

Debridement Closure

Hernia Repair49568, 49652-49657

The "Debridement Closure" entry should be removed from the CPT Index for 2010.

Index
Medical section

Medical Genetics 96040
Genetic Counseling96040
Medical Nutrition Therapy 97802-97804

Add new subheading "Medical Nutrition Therapy" and code range 97802-97804 to the medical section in the Index.



Index Fistula

Anal

Repair . . . 0170T, 46288, **46706** ~~46708~~

Delete reference code 46708 and replace with 46706 in the index following the Fistula anal repair subheading.

Index Placement

Gastrostomy tube . . . 43246, 49440

Revise misspelled term "gastrostomy" in the Index following the Placement subheading.

Medium Descriptors

28060 FASCIECTOMY PLANTAR FASCIA PARTIAL SPX

Revise medium descriptor for 28060.

Medium Descriptors

96376 THER PROPH/DX NJX EA SEQL IV PUSH SBST/DRUG FAC

Revise medium descriptor for 96376.



Category II

- 0519F Planned chemotherapy regimen, including at a minimum: drug(s) prescribed, dose, and duration, documented prior to initiation of ~~course of treatment~~ a new treatment regimen (ONC)¹

Delete the language “course of treatment” and add the language “a new treatment regimen” to code 0519F:

Diagnostic/Screening Process or Results

- 3290F Patient is D (Rh) negative and unsensitized (~~Prenatal~~ Pre-Cr)¹
- 3291F Patient is D (Rh) positive or sensitized (~~Prenatal~~ Pre-Cr)¹
- 3292F HIV testing ordered or documented and reviewed during the first or second prenatal visit (~~Prenatal~~ Pre-Cr)¹

Therapeutic, Preventive, or Other Interventions

- 4178F Anti-D immune globulin received between 26 and 30 weeks gestation ((~~Prenatal~~ Pre-Cr)¹

Change suffix for codes used in “Prenatal Care clinical topic” (3290F-3292F, 4178F) from “Prenatal” to “Pre-Cr”.

Therapeutic, Preventive, or Other Interventions

- 4200F External beam radiotherapy as primary therapy to the prostate (PRCA)¹

Add the words “. . . as primary therapy” and “. . . the . . .” to the descriptor for code 4200F.

Appendix H Changes

<p>Back Pain (BkP)</p>
<p>Brief Description of Performance Measure & Source</p>
<p>Physical Exam after Back Pain Onset² Whether or not a patient with a diagnosis of back pain received a physical examination during the initial visit for the episode of back pain</p> <p>Numerator: Patients who had a physical exam on the date of the initial visit for back pain*</p> <ul style="list-style-type: none"> • For patients with radicular symptoms, documentation of physical exam must include the following (at a minimum): <ul style="list-style-type: none"> – Indication of straight leg raise test, and – Notation of completion of neurovascular exam (a neurovascular exam must include ankle and knee reflexes; quadriceps, ankle and great toe dorsiflexion strength; plantar flexion; muscle strength; motor testing; pulses in lower extremities; and sensory exam) • For patients without radicular symptoms, documentation of physical exam must include the following: <ul style="list-style-type: none"> – Documentation of straight leg raise or neurovascular exam or clear notation of absence or presence of neurologic deficits <p>Denominator: All patients with diagnosis of back pain at the initial visit of the episode</p> <p>Exclusion(s): Medical exclusion for not receiving a physical examination (ie, patients with bilateral lower extremity amputations)</p> <p>Percentage of patients with a diagnosis of back pain who received a physical examination on the date of the initial visit</p> <p>Reporting Instructions: Report 0525F or 0526F for each patient. Use code 0525F to indicate the initial visit and 0526F to indicate a subsequent visit during the episode of low back pain. Only initial visits (0508F0525F) will be included in the numerator. Report 2040F if a physical exam occurred as specified. There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used. <u>If there is a valid medical reason for not receiving a physical examination during the initial visit for the episode of back pain, report 1P with 2040F</u> <u>*Note: Measure specifications should be referred to in order to determine criteria to meet any of the required assessments.</u></p>

Replace code number 0508F for (0525F) and include corrected reporting instruction regarding 1P modifier in Appendix H measure for Physical Exam after Back Pain Onset² measure in the Back Pain measure set.

Major Depressive Disorder (MDD)

Brief Description of Performance Measure & Source

Depression Screening and Assessment in High Risk Patients²

Whether or not a patient who is 18 years and older and is identified in a high risk category (ie, age or condition) ~~who~~ has a documented result from a depression screen or assessment during the measurement year.

Numerator:

Documented results of depression screen or assessment during the measurement year.

Note: Patients who are screened positive for depressive symptoms who do not receive further assessment of depressive symptoms with a standardized tool do not count toward the numerator.

Documentation of any one of the following counts toward this measure:

- *Negative screen for depressive symptoms using a standardized tool***
- *No significant depressive symptoms using a standardized tool***
- *Mild to moderate depressive symptoms using a standardized tool***
- *Clinically significant depressive symptoms using a standardized tool***

*Note: Measure specifications should be referred to determine criteria to meet any of the listed risk categories (ie, the denominators.)

**Note: Measure specifications should be referred to identify acceptable standardized tools for screening and assessment.

Denominator:

Adults, 18 years and older, who have been identified in one or more of following the high risk categories (ie, age or condition)*:

- Patients with diabetes
- Patients with cardiovascular disease including acute myocardial infraction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)
Two methods can be used to identify the eligible population: 1) a cardiac event or 2) an ischemic vascular disease (IVD) diagnosis. For the cardiac event (AMI, CABG, or PTCA) the look back is from January 1 through November 1 of the year prior to the measurement year; for the IVD diagnosis the look back is the measurement and the year prior to the measurement year.
- Patients with persistent asthma
- Patients with chronic obstructive pulmonary disease (COPD)
- Patients with low back pain
- Patients who are 65 years and older

Exclusion(s): None

REPORTING INSTRUCTIONS:

Report code 3351F, 3352F, 3353F, or 3354F for patients identified as high risk when acceptable screening or assessment has been documented. There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.

**Note: Measure specifications should be referred to identify acceptable standardized tools for screening and assessment.

Delete the word “who” in the Appendix H measure statement for the Depression Screening and Assessment in High Risk Patients² measure, Major Depressive Disorder (MDD)



Hepatitis C (HEP C)

Hepatitis C Ribonucleic Acid (RNA) Testing Before Initiating Therapy¹
Whether or not . . .

Add the superscript for “Hepatitis C Ribonucleic Acid (RNA) Testing Before Initiating Therapy¹” measure

▶ Prenatal Care (Prenatal <u>Pre-Cr</u>) ◀		
Brief Description of Performance Measure & Source	CPT Category II Code(s)	Code Descriptor(s)
▶ Anti-D Immune Globulin ¹ -Whether or not the . . .		

Revision of clinical topic heading to reflect revision made to suffix abbreviation for Prenatal Care clinical topic

MEDIUM DESCRIPTOR REVISIONS:

Revise code 1136F from “6 WEEKS” to “12 WEEKS”

1136F EPISODE OF BACK PAIN LASTING ~~6~~12 WEEKS OR LESS

Revise code 4040F replace “IMMUNIZATION ORDERED/ADMINISTERED” to “VACCINE ADMIN RCVD B/4”

4040F ~~PNEUMOCOCCAL IMMUNIZATION ORDERED/ADMINISTERED~~ VACCINE ADMIN RCVD B/4