Code change instructions

Before completing the coding change form, first become familiar with the introductory material and guidelines included within *Current Procedural Terminology, Fourth Edition* and the CPT conventions (e.g., semicolon, the indent, “separate procedure,” cross-references, etc.).

Review current codes

Review the index of CPT before concluding that there are no codes to use for a particular procedure, as they might be located in a section that you are not familiar with. Also, please consider, to the degree possible, what other section of CPT might be affected when making changes in a particular area and list the complete family of codes related to your request. This will allow the CPT Advisory Committee and Editorial Panel to perform a full review on the impact of your request on related codes.

In your proposal, please clearly identify the items that you are proposing to add, modify or delete. Use the conventional techniques of strikeouts for deletions, underlining for additions and/or modifications, bullets ? for new codes, and triangles ? for revised codes.

Example of how your proposed change should appear

? 33860 Ascending aorta graft, with cardiopulmonary bypass and without valve suspension

? 338X1 with coronary reconstruction

? 338X2 with aortic root replacement using composite prosthesis and coronary reconstruction

Development of clinical vignette

A clinical vignette is required for each code change request (except for minor editorial changes). A clinical vignette describes the typical patient who would receive the procedure(s)/service(s) including diagnosis and relevant conditions. A sample format to use in developing a clinical vignette for a procedure and/or service is included with this material. This same vignette is used during the development of work values by the AMA/Specialty Society RVS Update Committee (RUC). The coding change request form has been revised to include coding changes for 3 different categories of CPT codes. The intent of each of the 3 categories of codes is different and it is important to
understand the uses for each. Please review the criteria for the Category I and III codes and Category II codes before submitting an application.

Before submitting changes/additions, also review the following questions:

**Is the suggestion a fragmentation of an existing procedure/service?**

Generally, all the components of a procedure are included in the code for a procedure. For example, CPT code 58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s), includes all of the components listed if they are performed at that operative session.

Requesting a new code for total abdominal hysterectomy (corpus and cervix), with removal of tubes would be an example of fragmentation. However, if the physician intended to perform an abdominal hysterectomy with bilateral salpingo-oophorectomy but only removed both tubes (bilateral salpingectomy), CPT code 58700 Salpingectomy, complete or partial, unilateral or bilateral (separate procedure) would be used to report this component of what is normally considered an integral part of a total service.

To summarize, if there are several components of a procedure that are usually performed as part of that procedure, a separate code is not generally assigned for each component, unless the component is performed alone. The separate procedure is indicated after that procedure.

In the example above, creating a code for total abdominal hysterectomy (corpus and cervix) with removal of tubes would fragment an existing procedure that already includes these components when they are performed as well as additional components (bilateral removal of ovaries).

**Can the suggested procedure/service be reported by using 2 or more existing codes?**

Certain procedures describe only a portion of a surgery performed, such as resection of a lesion or tumor. The procedure that is performed after the resection will vary, depending on the individual patient and the extent of the disease or other complicating factors. This may require reporting 2 or more procedure codes to completely indicate the services/procedures performed to treat 1 problem.

For example, CPT code 42120 Resection of palate or extensive resection of lesion, identifies the surgical resection performed, but the repair of the defect will depend on the exact location of the
lesion and the extent of the resection. An adjacent tissue transfer or a free skin graft may be performed, or a flap or surgical obturator may be used to repair the defect. The CPT Editorial Panel does not try to create codes which cover all possible combinations for the removal/resection of the lesion and the subsequent repair. It is expected that 2 or more codes will be used to report these procedures.

Does the suggested procedure/service represent a distinct service?

CPT lists descriptive terms and identifying codes used to report medical services and procedures. Review the proposed coding change/addition. What does the actual service involve? If the only service provided is the review information stored in computers and does not require performance of a test, CPT code 99090 Analysis of clinical data stored in computers (e.g., ECG, blood pressures, hematologic data) can be used to report this analysis. While many sophisticated devices and equipment to perform procedures or provide services exist, CPT’s intent is to list those services/procedures in which actual work performance or direct supervision is required from a physician or practitioner. The device/equipment they use is not listed in the code.

Is the suggested procedure/service merely a means to report extraordinary circumstances related to performance of procedure/service already included in CPT?

A modifier indicates that a service or procedure performed has been altered by some specific circumstance but not changed in its definition or code.

For example, if a physician performed a cholecystectomy on a patient who was morbidly obese, a cholecystectomy would still be reported. The fact that the physician spent 2 additional hours performing the surgery (because of the complexity of the procedure due to the obesity) does not change the actual procedure being reported. The physician may add modifier 22 to the reported cholecystectomy code. The physician should attach a copy of the operative report or a narrative note to the claim form when submitting it to the third-party payer, indicating the additional work involved to perform this particular procedure.

Submitting a code change request
If the answers to the preceding questions suggest a new descriptor/code is needed or you want to delete or revise procedure codes already in CPT, please submit your proposal by completing a coding change request application. Before submitting the application, also be sure to review the general and specific criteria for Category I, II and III codes.

Applications require the following information:

- A complete description of the procedure/service (i.e., describe in detail the skill and time involved. If this is a surgical procedure, include an operative report that describes the procedure in detail).
- A clinical vignette, which describes the typical patient and work provided by the physician/practitioner.
- The diagnosis of patients for whom this procedure/service would be performed.
- A copy(s) of peer reviewed articles published in U.S. journals indicating the safety and effectiveness of the procedure, as well as the frequency with which the procedure is performed and/or estimation of its projected performance.
- A copy(s) of additional published literature which you feel further explains your request (e.g., practice parameters/guidelines or policy statements on a particular procedure/service).
- Evidence of FDA approval of the drug or device used in the procedure/service, if required.

Provide rationale for each code proposed relative to existing code set

Refer to the current section of CPT to which you believe the proposed code/coding change relates. In your letter, provide the rationale to answer the following questions:

- Why aren't the existing codes adequate? (Be very specific).
- What specific descriptors are you proposing? (Suggest wording for what you are proposing as well as placement of the proposed code(s) within the existing code range).
- Can any existing codes be changed to include these new procedures without significantly affecting the extent of the services? (If not, give reasons why the existing codes are deficient).
- Give specific rationale for each code you are proposing, including a full explanation on how each proposed code differs from existing CPT codes.
- If a code is recommended for deletion, how should the service then be coded?
- How long (e.g., number of years) has this procedure/service been provided for patients?
- What is the frequency in which a physician or other practitioner might perform the procedure/service?
- What is the typical site where this procedure is performed (e.g., office, hospital, nursing facility, ambulatory or other outpatient care setting, patient's home)?
- Does the procedure/service involve the use of a drug or device that requires FDA approval?

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Submitting an application does not ensure that the CPT Editorial Panel will adopt your suggestion.

Since the initial AMA staff and CPT Advisory Committee review process takes several weeks, contact AMA staff for any questions related to the deadline dates and schedule which apply to a particular CPT year cycle.

CPT schedule information is also available on the CPT Editorial Panel Process Calendar. Following preliminary finalization of the panel minutes, AMA staff will notify you of the action that the CPT Editorial Panel has taken on your application.

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