



## CORRECTIONS DOCUMENT —CPT® CHANGES 2017 *An Insider's View*

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### Surgery

#### Musculoskeletal System

#### Foot and Toes

#### Repair, Revision, and/or Reconstruction

#### Description of Procedure (28291)

Preadmission orders for preoperative medications are written. Pre procedural imaging, pathology, and laboratory studies are reviewed, with special attention to imaging and exam of ipsi and contralateral lower extremities. Admission history and physical are performed and documented in the facility medical record. The planned procedure and postoperative management are reviewed with the patient and family. The operative foot is marked prior to informed consent being reviewed with the patient. The length and type of anesthesia are reviewed with the anesthesiologist. Availability of all required instruments and supplies is verified. Patient positioning, padding of bony prominences, and application of thermal regulation drapes are monitored and/or assistance is provided. The position of the extremities and head are assessed and adjusted as needed. The patient's leg is positioned with proper bolstering to aid surgical exposure. Positioning of fluoroscopic equipment is supervised. Areas of the skin to be prepared are indicated, and surgical incisions are marked. An ankle tourniquet is placed. The leg is prepared and draped. The surgeon scrubs and puts on a gown. A surgical time-out is performed with the operating team. The leg is elevated and exsanguinated. The pneumatic tourniquet is inflated. Under anesthesia, a skin incision is centered over the first metatarsophalangeal joint. The neurovascular structures are identified and protected. The incision is carried down to the joint capsule, and the capsule is elevated off of the metatarsal head and base of the proximal phalanx. Osteophytes are excised from the metatarsal head and base of the proximal phalanx. The articular cartilage is removed from the joint surfaces. The medullary canal of the metatarsal head and base of the proximal phalanx are reamed to the appropriate size. The area is copiously irrigated. The implant is placed and assessed for size and stability. Joint range of motion is evaluated. The tourniquet is deflated, and hemostasis is obtained. The wound is inspected and irrigated. Redundant joint capsule is removed, and the capsule is repaired. Local anesthetic medication is injected for postoperative pain control. The wound is closed in layers.

**Revise the description of procedure for code 28291 to include the intraservice portion as it was inadvertently omitted from the publication.**

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### Surgery

#### Cardiovascular System

#### Heart and Pericardium

## Cardiac Valves

### Aortic Valve

- **33390** Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (ie, valvotomy, debridement, debulking, and/or simple commissural resuspension)
- **33391** complex (eg, leaflet extension, leaflet resection, leaflet reconstruction, or annuloplasty)

#### Clinical Example (33390)

A 3-year-old male born with congenital aortic stenosis presents with recurrent valvular aortic stenosis and mild insufficiency following balloon valvuloplasty of his bicuspid aortic valve as a neonate. The family reports decreased exercise tolerance, with shortness of breath and easy fatigability. Electrocardiogram (EKG) shows left ventricular hypertrophy. Echocardiogram documents a 60 mmHg gradient across the aortic valve, with residual fusion of the commissure between the left and noncoronary cusps and dysplastic thickening of the leaflets beneath this area.

#### Description of Procedure (33390)

A sternotomy is performed, the thymus is divided or resected, the pericardium is opened and suspended, and appropriate purse string sutures are heparinized and placed for cannulation. ~~The patient is heparinized and~~ Arterial and venous cannulas are inserted for cardiopulmonary bypass (CPB), which is initiated after adequate anticoagulation is ensured. The left atrial vent is inserted, and cooling is initiated as appropriate. The cardioplegia delivery catheter is placed, the aorta is cross-clamped, and cardioplegia is administered. An appropriate ascending aortotomy is performed. The valve is repaired; this may include valvotomy, debridement, debulking, or simple commissuroplasty. The aortotomy is closed. Egress for potential retained intracardiac air is ensured, and the aortic cross-clamp is removed. The heart is rewarmed and resuscitated. Temporary pacing wires are placed as indicated. The left atrial vent is removed. Wean from CPB, and postrepair TEE is reassessed for potential retained intracardiac air, adequacy of valve repair, and ventricular function. Heparin reversal with protamine after decannulation from CPB is directed. Appropriate mediastinal and pleural tubes are placed, hemostasis is ensured, and the pericardium (primary or with patch augmentation) is closed as appropriate. The sternotomy incision is closed.

#### Clinical Example (33391)

A 52-year-old male with a bicuspid aortic valve presents with valvular aortic stenosis and severe aortic insufficiency. He reports decreased exercise tolerance, with shortness of breath and easy fatigability. EKG shows left ventricular hypertrophy and a 40 mmHg gradient across the aortic valve, with severe aortic insufficiency due to fusion of the commissure between the left and noncoronary cusps with retraction and dysplastic thickening of the aortic valve leaflets.



### Description of Procedure (33391)

A sternotomy is performed, the thymus is divided or resected, the pericardium is opened and suspended, and appropriate purse string sutures are ~~heparinized and~~ placed for cannulation. ~~The patient is heparinized and~~ Arterial and venous cannulas are inserted for CPB, which is initiated after adequate anticoagulation is ensured. The left atrial vent is inserted, and cooling is initiated as appropriate. The cardioplegia delivery catheter is placed, the aorta is crossclamped, and cardioplegia is administered. An appropriate ascending aortotomy is performed. The valve is repaired; this may include resection of thickened rudimentary commissure with reconstruction using a pericardial patch. The valve commissures are resuspended, and a subvalvular annuloplasty is performed in addition to debulking the thickened aortic valve leaflets. The aortotomy is closed. Egress for potential retained intracardiac air is ensured, and the aortic cross-clamp is removed. The heart is rewarmed and resuscitated. Temporary pacing wires are placed as indicated. The left atrial vent is removed. Wean from CPB, and postrepair TEE is assessed for potential retained intracardiac air, adequacy of valve repair, and ventricular function. Heparin reversal with protamine after decannulation from CPB is directed. Appropriate mediastinal and pleural tubes are placed, hemostasis is ensured, and the pericardium (primary or with patch augmentation) is closed as appropriate. The sternotomy incision is closed.

**Revise the description of procedure for codes 33390, 33391 to clarify that the patient was heparinized.**

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## Medicine

### Vaccines, Toxoids

- #● **90674** Influenza virus vaccine, quadrivalent (ccIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use

### Clinical Example (90674)

A 52-year-old male presents at his physician's office for his annual physical and evaluation in October. His physician tells him that the Advisory Committee on Immunization Practices advises that anyone 6 months of age and older who does not have contraindications to vaccination, should receive an annual vaccination against influenza before the start of the influenza season.

### Description of Procedure (90674)

During the annual influenza vaccination season, as part of the patient's overall visit and evaluation and per the physician's office standing orders, an influenza vaccination is administered by a registered nurse (RN). A vaccine information sheet that summarizes the risks and benefits of vaccination as well as potential side effects is provided by the RN. The injection site is evaluated, antisepsis is applied, and the injection is provided



intramuscularly. Standard medical practice of a 15-minute waiting period post vaccination is recommended.

**Add vignette for new code 90674.**

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