

CORRECTIONS DOCUMENT —CPT® CHANGES 2022 An Insider's View

Radiology

Bone/Joint Studies

Description of Procedure (77089)

Verify the previously acquired images (eg, dual-energy X-ray absorptiometry [DEXA], etc) are appropriate for trabecular bone score (TBS) analysis by ensuring the quality and that no anatomy or artifact is excluded. Open the images in the TBS software, separate from the picture archive and communication system (PACS), and verify that those images have transferred appropriately. Identify the appropriate population reference control. Review the images to determine the region to be included in calculations. Interpret the TBS data and compare the data to established norms, including risk analysis to determine if fracture risk analysis (reported separately) is indicated. Compare the results to previous studies. Compare the reported values to population standards. Transfer the TBS images to PACS. Dictate a report.

Description of Procedure (77092)

Verify the previously acquired images (eg, DEXA, etc) are appropriate for TBS analysis by ensuring the quality and that no anatomy or artifact is excluded. Open the images in the TBS software, separate from PACS, and verify that the images have transferred appropriately. Identify the appropriate population reference control. Review the images to determine the region to be included in calculations. Interpret the TBS data and compare the data to established norms, including risk analysis to determine if fracture risk analysis (reported separately) is indicated. Compare the results to previous studies. Compare the reported values to population standards. Transfer the TBS images to PACS. Dictate a report.

Revise the description of procedure for codes 77089 and 77092 by removing the “E” to indicate the abbreviation “DXA”.

Pathology and Laboratory

Pathology Clinical Consultations

Instructions for Selecting a Level of Pathology Clinical Consultation Services

Description of Procedure (80503)

N/A

The provider consults the pathologist. The pathologist reviews the clinical history in the patient's medical record(s), which may include, but is not limited to, the history of present and past illness, medical and surgical history, imaging data, medication lists, transfusion history, social history, and travel history. Review the patient's medical record, focusing on recent and relevant remote clinical and diagnostic findings. Retrieve and unarchive all applicable diagnostic material, slides, and primary analytical data for the pathologist's examination and review. The pathologist assesses the relevant results or findings to include, but not limited to, hematology, coagulation, chemistry, microbiology, molecular and genetic studies, and/or any peripheral blood smear(s), cytopathologic, and



histopathologic preparation(s). The pathologist integrates all data and information for clinical correlation and medical decision making (MDM) and documents the service in the medical record. The pathologist may also discuss case findings with the requesting provider and/or clinical team (by phone, face to face, or virtually), and provide recommendations for additional testing and further clinical evaluation. (When using time for code selection, 5 to 20 minutes of total time is spent on the date of the consultation.)

Description of Procedure (80504)

N/A

The provider consults the pathologist. The pathologist reviews the clinical history in the patient's medical record(s), which may include, but is not limited to, the history of present and past illness, medical and surgical history, imaging data, medication lists, transfusion history, social history, and travel history. Review the patient's medical record, focusing on recent and relevant remote clinical and diagnostic findings. Retrieve and unarchive all applicable diagnostic material, slides, and primary analytical data for the pathologist's examination and review. The pathologist assesses the relevant results or findings to include, but not limited to, hematology, coagulation, chemistry, microbiology, molecular and genetic studies, and/or any peripheral blood smear(s), cytopathologic, and histopathologic preparation(s). The pathologist integrates all data and information for clinical correlation and MDM and documents the service in the medical record. The pathologist may also discuss case findings with the requesting provider and/or clinical team (by phone, face to face, or virtually), and provide recommendations for additional testing and further clinical evaluation. (When using time for code selection, 21 to 40 minutes of total time is spent on the date of the consultation.)

Description of Procedure (80505)

N/A

The provider consults the pathologist. The pathologist reviews the clinical history in the patient's medical record(s), which may include, but is not limited to, the history of present and past illness, medical and surgical history, imaging data, medication lists, transfusion history, social history, and travel history. Review the patient's medical record, focusing on recent and relevant remote clinical and diagnostic findings. Retrieve and unarchive all applicable diagnostic material, slides, and primary analytical data for the pathologist's examination and review. The pathologist assesses the relevant results or findings to include, but not limited to, hematology, coagulation, chemistry, microbiology, molecular and genetic studies, and/or any peripheral blood smear(s), cytopathologic, and histopathologic preparation(s). The pathologist integrates all data and information for clinical correlation and MDM and documents the service in the medical record. The pathologist may also discuss case findings with the requesting provider and/or clinical team (by phone, face to face, or virtually), and provide recommendations for additional testing and further clinical evaluation. (When using time for code selection, 41 to 60 minutes of total time is spent on the date of the consultation.)

Description of Procedure (80506)

N/A

Continue the work of pathology consultation, lasting at least 15 minutes beyond the service time of code 80505 that includes tasks such as assessing the additional relevant data and clinical information, with further analyses and MDM. The pathologist documents the prolonged service or increased complexity of MDM.



Updated the description of procedure for codes 80503, 80504, 80505, and 80506 by removing “N/A” and adding the procedure descriptions.

Medicine

Cardiovascular

Intracardiac Electrophysiological Procedures/Studies

Description of Procedure (93653)

Confirm that direct current cardioversion/defibrillation and electrophysiology (EP) testing/ablation equipment is present and in proper working order. Test fluoroscopic equipment that will be used to visualize catheter movement and location. Administer local analgesia with anesthesia that is appropriate for the patient, including moderate sedation. Obtain venous access. Arterial access to monitor blood pressure and to facilitate retrograde aortic access to the left ventricle may be obtained. Advance the multielectrode catheters from the access sheaths into the respective cardiac chambers where they will be used to pace and record. Perform pacing and sensing in the right atrium, left atrium, and right ventricle. Obtain a recording of the bundle of His and measure the refractory periods. Attempt arrhythmia induction via maneuvers such as burst pacing and premature pacing using programmed electrical stimulation at multiple drive-cycle lengths from multiple atrial and ventricular sites. Once the SVT is induced, perform pacing maneuvers to elucidate the mechanism of the tachycardia. Perform a combination of diagnostic maneuvers and generate a high-definition anatomical map of the chamber(s) of interest. Perform voltage and electrical activation in the arrhythmia and/or in sinus rhythm to identify normal activation, the location of the scar, and the mechanism of the arrhythmia, and then perform catheter ablation. Maneuver the ablation catheter from the sites of vascular access to the appropriate cardiac location to facilitate delivery of ablative energy. Deliver multiple lesions to ensure eradication of the arrhythmia focus, and provide consolidation lesions in the surrounding tissue. Consolidation of lesions simply means deliver more ablation points. During the course of the EP procedure, an induced arrhythmia requires the use of an advanced 3D computer mapping system to assist in identifying the arrhythmia circuit and localizing the origin (for focal arrhythmias) or the critical isthmus (for reentrant arrhythmias). Calibrate the 3D mapping system and obtain recordings during sinus rhythm (to identify normal activation and location of the scar) and during each distinct arrhythmia. The physician analyzes the computer-generated map to ensure the electrograms are annotated correctly and the display parameters are correct for the specific arrhythmia being mapped. Based on the data from the 3D mapping system, endocardial electrograms, the surface ECG, and the response of the SVT to pacing maneuvers, advance the ablation catheter to the point of earliest activation as localized by the mapping system to identify a mid-diastolic potential, Kent potential, and/or similar paced maps. When a reentrant circuit is identified, perform and evaluate entrainment mapping studies to confirm the catheter location is within the reentrant circuit, and then perform radiofrequency (or cryo) ablation. If initial mapping in one chamber does not lead to complete identification of the essential arrhythmia circuit (either based on analysis of the map or based on an incomplete ablation result), move the mapping catheter(s) into another cardiac chamber and generate an additional 3D map to aid in diagnosis; repeat the procedure until the arrhythmia mechanism is fully characterized and ablation is deemed completely successful. Prepare a final report that includes the mapping procedure and findings.

To record left atrial activity, the femoral venous access site is already prepared for a related procedure. Achieve central venous access and place a sheath in the femoral vein using standard percutaneous techniques, changing to subclavian or jugular access if that fails. Introduce the catheter



into the sheath and advance into the right atrium where the ostium of the coronary sinus is engaged. Advance the catheter into the coronary sinus. Use the multielectrode catheter to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Reposition the catheter as necessary throughout the course of the cardiac EP procedure to optimize recordings and pacing thresholds. At the conclusion of the procedure, remove the catheter. Include a description of this additional work and catheter use and associated findings in the procedure report. Throughout the ablation, monitor the patient for hemodynamic compromise due to cardiac perforation or tachyarrhythmias, embolic phenomena, or damage to cardiac or vascular structures. Following the ablation portion of the procedure, perform repeat electrophysiologic testing to assess the outcome of ablation using decremental, burst, and premature pacing maneuvers. Repeat these procedures at the conclusion of a 30-minute waiting period following the final ablation lesion. If the tachycardia demonstrates recovery or incomplete suppression, perform repeat mapping and ablation as described above, and repeat these steps until the tachycardia is rendered durably suppressed. Remove the sheaths, achieve appropriate hemostasis, and perform a follow-up assessment of the patient for any complications.

Revise the description of procedure for code 93653 to clarify that consolidation of lesions means deliver more ablation points.

Medicine

Pulmonary

Pulmonary Diagnostic Testing, Rehabilitation, and Therapies

Description of Procedure (94625)

Perform a review of systems and review and confirm key information from the patient's medical records with the patient. The physician reviews the patient's current vital signs including oxygen saturation (SpO₂) at rest and during exercise and compares them with previous readings. The physician decides whether the patient is fit to participate in the pulmonary rehabilitation program, ~~and whether the patient will require monitoring during the exercise and strengthening portion of the program, and a decision is made that continuous oximetry monitoring is not necessary.~~ The physician is required to be immediately available during the exercise session, and the physician will perform face-to-face evaluation of the patient for any acute issues that arise, including ~~oxygen desaturations beyond baseline~~ tachypnea or respiratory distress, tachycardia, hypertension or hypotension, or symptoms of acute illness, such as developing acute exacerbation of COPD.

Description of Procedure (94626)

Perform a review of systems and confirm key information from the patient's medical records with the patient. The physician reviews the current vital signs including SpO₂ at rest and during exercise and compares them with previous readings. The physician decides whether ~~or not~~ the patient is fit to participate in the pulmonary rehabilitation program, and whether the patient will require supplemental oxygen (and the amount of oxygen). ~~and monitoring during the exercise and strengthening portion of the program.~~ The decision is made that continuous oximetry monitoring is indicated during the exercise and strengthening portion of the program. The physician is required to be immediately available during the exercise session, and the physician will perform face-to-face evaluation of the patient for any acute issues that arise, including oxygen desaturations beyond baseline or despite supplemental oxygen, tachypnea or respiratory distress, tachycardia, hypertension or hypotension, or symptoms of acute illness, such as developing acute exacerbation of COPD.



Revise the description of procedure for code 94625 to include the decision for continuous oximetry monitoring is not necessary, and revise the description of procedure for code 94626 to include the decision for continuous oximetry monitoring is indicated.