New CPT Codes for 2014

Get ready for the changes effective January 1.

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Multiple families of new and/or revised CPT codes take effect January 1, 2014. This month's article will introduce those changes to help you and your practice prepare for the necessary changes. More in-depth discussion of some of these codes will be presented in future columns.

VASCULAR STENTING

New codes were developed that bundle the surgical and radiologic portions of stent procedures into a single code. There are two new pairs of codes, one for arterial stents and one for venous stents. These codes are reported per vessel treated rather than per stent placed. For dialysis access treatment coding purposes, the definition of "vessel" is different than the anatomical definition and should be reviewed in the CPT manual to ensure correct reporting. Each pair of stent codes has a parent code used to report the first vessel treated, with an add-on code for reporting additional stented vessels during the same procedure.

The arterial stent codes apply to any artery that does not have an anatomy-specific CPT code (carotid, iliac and infrainguinal, intracranial, coronary, and vertebral arteries have specific stent placement codes). Any ballooning performed to treat the stented vessel (before, during, or after stent placement) is included in the work of the stent codes and is not separately reported. Selective catheterization of the vessel(s) is not included in the work described by the stent codes and is separately reported. In addition, ultrasound guidance for vessel puncture and intravascular ultrasound are not included in the work of these codes.

Covered stents placed to treat aneurysms (eg, popliteal aneurysms), pseudoaneurysms, or extravasations are coded with these new stent codes (with the exception of aortic and iliac aneurysms, which are reported with codes specific for endovascular repair of aneurysms in those anatomic sites). Stents placed to create latticework for facilitating coil embolization are reported with embolization codes and should not be reported with the new stent codes.

Coding

- 37236: Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery
    - +37237: each additional artery
- 37238: Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein
    - +37239: each additional vein

Erratum: These codes (37236-37239) would be used to report placement of covered stents for aneurysms, except for vessels where there are codes specific for the vessel being treated. There is an existing CPT code for placement of a popliteal stent (37226), and this code would be used to report treatment of a popliteal aneurysm with a covered stent rather than one of the new, generic arterial stent codes.

EMBOLIZATION

Four new codes were created to describe nonneurologic embolization procedures. These codes bundle the surgical and radiological portions of the work of embolization into single codes. Four categories of embolization were identified as separate types of work:

1. General venous
2. General arterial
3. Arterial treatment of tumors
4. Arterial/venous/lymphatic hemorrhage or extravasation

These codes do not include the work of selective catheterization of the vessel(s) embolized, diagnostic angiography if performed, ultrasound guidance for vessel access, or the work of handling and dosing chemotherapy or radiotherapy. Those services may be separately reported when performed. The existing codes 37204 (previous embolization code) and 37210 (specific code for uterine fibroid embolization) were deleted from CPT and can no longer be used. The radiologic supervision and interpretation codes 75894 (embolization) and 75898 (follow-up angiography during embolization) were not deleted but should not be reported with the new embolization codes because those portions of work are included in the new bundled embolization codes.

Coding

- 37241: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)
    - 37242: arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)
    - 37243: for tumors, organ ischemia, or infarction
    - 37244: for arterial or venous hemorrhage or lymphatic extravasation

FEVAR

A set of eight new codes will be available to report fenestrated endograft repair of the abdominal and visceral aorta (FEVAR). Four codes describe the placement of a fenestrated device to treat the visceral aorta only, and four codes describe placement of a fenestrated device that extends across the visceral aorta and into the infrarenal aorta and/or iliac(s). Unlike the existing codes for EVAR, these new codes bundle additional components of the work of the procedure into a single code. Selective catheterization of the aorta and visceral arteries, stenting of any visceral vessels, and the radiologic supervision and interpretation are all included in the work of the FEVAR codes (and not separately reported as they are with the other abdominal and thoracic EVAR codes). As with the other EVAR codes, any angioplasty and/or stenting performed within the target treatment zone of the endograft is included in the work described by the FEVAR codes.

Because the current technology requires extensive measurement and planning services that are performed several weeks prior to the implant procedure, this portion of the work is not included in the FEVAR codes, which is also different than the other codes describing endovascular repair of abdominal and thoracic aortic aneurysms. It is anticipated that a separate code to report this work will be developed for 2015. Placement of a proximal extension or cuff is not reported separately with the FEVAR codes, but distal extensions or cuffs may be separately reported.

Coding

- 34841: Endovascular repair of the visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac, or renal artery)
    - 34842: including two visceral artery endoprostheses (superior mesenteric, celiac, and/or renal artery[s])
    - 34843: including three visceral artery endoprostheses (superior mesenteric, celiac, and/or renal artery[s])
    - 34844: including four or more visceral artery endoprostheses (superior mesenteric, celiac, and/or renal artery[s])
- 34845: Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and a concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac, or renal artery)
    - 34846: including two visceral artery endoprostheses (superior mesenteric, celiac, and/or renal artery[s])
    - 34847: including three visceral artery endo-

prostheses (superior mesenteric, celiac, and/or renal artery[s])
- 34848: including four or more visceral artery endoprostheses (superior mesenteric, celiac, and/or renal artery[s])

INTRATHORACIC COMMON CAROTID/ INNOMINATE STENT PLACEMENT

Code 37217 was created to report the placement of an intrathoracic common carotid or innominate artery stent from an open, retrograde exposure. This code includes the work of the open exposure, selective catheter placement, all angioplasty performed, stent placement, and all imaging guidance.

PERCUTANEOUS ABSCESS/FLUID COLLECTION DRAINAGE

Four new codes are being introduced to describe percutaneous drainage of fluid collections. These codes bundle the surgical procedure with all imaging guidance used for the procedure into single codes. The imaging guidance may be fluoroscopy, ultrasound, computed tomography, magnetic resonance imaging, or any combination of those modalities. These codes replace the former set of codes that included organ-specific descriptors and are designed to apply to drainage procedures for all types of fluid collections rather than specifically for abscesses. Moderate sedation is included in these codes.

Coding

- 10030: Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck); percutaneous
- 49405: Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous
- 49406: Peritoneal or retroperitoneal, percutaneous
- 49407: Peritoneal or retroperitoneal, transvaginal, or transrectal

BREAST BIOPSY AND BREAST LOCALIZATION

There are six new codes describing breast biopsy and placement of localization device(s) performed with imaging guidance (19081–19086) and eight new codes describing placement of breast localization device(s) performed with imaging guidance (19281–19284). These codes are specific to the type of imaging guidance performed (mammographic, stereotactic, ultrasonic, or magnetic resonance imaging).

Coding

- 19081: Biopsy of the breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance
  - +19082: each additional lesion, including stereotactic guidance
- 19083: Biopsy of the breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance
  - +19084: each additional lesion, including ultrasound guidance
- 19085: Biopsy of the breast with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance
  - +19086: each additional lesion, including magnetic resonance guidance
- 19281: Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance
  - +19282: each additional lesion, including mammographic guidance
- 19283: Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance
  - +19284: each additional lesion, including stereotactic guidance
- 19285: Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance
  - +19286: each additional lesion, including ultrasound guidance
- 19287: Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance
  - +19288: each additional lesion, including magnetic resonance guidance. ■

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