Key CPT Changes 2011

Guidelines on Time

The CPT Introduction includes new standards for time measurement for those codes or code ranges without specific instructions. The standards include the following guidance:

- Time is the face-to-face time with the patient
- Phrases such as “interpretation and report” is not intended to indicate that report writing is part of the reported time
- A unit of time is met when the mid-point is passed (e.g. an hour is attained when 31 minutes has passed)
- Time that falls between two times for codes ranked in sequential typical times is reported using the code with the closest actual time
- Only the time for providing the time-based code can be used in the selection of the code. Time spent in other concurrent services, such as procedures, should not be considered in the selection of the time-based code.
- Time for services measured in units other than days are considered continuous times even if the service extends into another calendar date. The date of service on which the service began should be reported as the date of service.

Observation Care Codes

Three codes have been added to report services provided to patients receiving observation care on days other than the admission or discharge date. The codes include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient’s status (i.e., changes in history, physical condition, and response to management) since the last assessment by the physician. The new codes are:

- **99224** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:
  - Problem focused interval history;
  - Problem focused examination;
  - Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient’s hospital floor or unit.
Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- An expanded problem focused interval history;
- An expanded problem focused examination;
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient’s hospital floor or unit.

Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- A detailed interval history;
- A detailed examination;
- Medical decision making of high complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient’s hospital floor or unit.

**Brachytherapy**

The symbol ☞ was placed in front of code 57155 (Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy) to indicate that the code includes moderate sedation.

A new code was added to the section to describe the insertion of radiation afterloading apparatus for clinical brachytherapy. The new code reads:

- 57156 Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy
**Introduction of Intraperitoneal Catheters**

A new code was added to describe the “complete” insertion of a tunneled intraperitoneal catheter. The term “permanent” was removed from existing codes 49419 and 49422 and replaced with the term “tunneled” to provide consistency with the descriptions for other catheter insertion codes and to better delineate the service performed. The new and revised codes are:

- **49418** Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous

- **49419** Insertion of tunneled intraperitoneal catheter, with subcutaneous port (ie, totally implantable)

- **49422** Removal of tunneled intraperitoneal catheter

**Intraperitoneal Chemotherapy Administration**

CPT deleted code 96445 and replaced it with code 96446. The new code better describes the current work associated with administration of intraperitoneal chemotherapy. Code 96445 included the phrase “requiring and including peritoneocentesis”. The new code deleted this phrase and reads:

- **96446** Chemotherapy administration into the peritoneal cavity via indwelling port or catheter

**Revisions to Debridement Codes**

The guidelines for selecting codes for wound debridement services (11042-11047) were revised. The codes are reported based on the depth of tissue removed and the surface area of the wound. The code is selected based on the deepest level of tissue removed. When multiple wounds are involved, the sum of the surface area of wounds of the same depth are added together to determine the code. Existing codes were revised and new add-on codes created to describe the surface area involved.
Modifiers

Modifiers 76, 77 (repeat procedures) and 78 (unplanned return to the OR) were revised to better reflect the intent of the modifiers. The term “other qualified healthcare provider” was added to the descriptors to clarify that these modifiers can be used by providers such as nurse practitioners and physician assistants in addition to physicians. Modifier 77 was revised to be consistent with the terminology for modifier 76 indicating that it can be reported with services other than procedures. Additional instructions for modifiers 76 and 77 specify they are not to be appended to an E/M Service code.

Modifier 50 was revised to delete the word “operative” to clarify that it can be appended to services other than surgical procedures.