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In This Issue:

- 3** CPT Coding for Rib Fracture Care
- 4** Diabetes Prevention Program
- 5** Coding Update: Central Nervous System Assessments/Tests (96110, 96127)
- 6** Coding Brief: Injection of Contrast for Knee Arthrography (27370)
- 7** ICD-10-CM Case Scenario
- 8** Frequently Asked Questions
- 9** CPT[®] and RBRVS 2016 Annual Symposium

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CPT Coding for Rib Fracture Care

For the 2015 CPT® code set, four Category III CPT codes (0245T-0248T) were converted to three new Category I CPT codes (21811–21813) to report open reduction and internal fixation of rib fractures. This article addresses the deletions and additions made to this set of musculoskeletal codes.

Code 21800, which previously described closed treatment of rib fracture, uncomplicated, was deleted because the standard practice no longer includes using strapping or rib belts as closed treatment for rib fractures. Currently, the predominate treatment for this type of fracture is pain control and perhaps an incentive spirometry. Therefore, a parenthetical note was added directing users to use the evaluation and management (E/M) services codes to report closed treatment of an uncomplicated rib fracture. In addition, code 21810, which previously described treatment of rib fracture that requires external fixation for the flail chest was deleted due to low utilization, and a parenthetical note was added to direct users to report 21899, *Unlisted procedure, neck or thorax, for external rib fixation procedures*.

New Codes

Category III codes 0245T-0248T were replaced with three new Category I codes, 21811-21813, to report open reduction and internal fixation of rib fracture(s), including thoroscopic visualization when performed. Each code is differentiated by the number of ribs treated. These codes are considered unilateral procedures. For bilateral procedures for which the same number of ribs is treated, report the primary code (21811-21813) with modifier 50 appended. If, however, a different number of ribs are treated on each side for bilateral procedures, then report each side separately with the appropriate code and append modifiers LT and RT.

Fracture and/or Dislocation

- ▶ (21800 has been deleted)◀
- ▶ (To report closed treatment of an uncomplicated rib fracture, use the Evaluation and Management codes)◀
- ▶ (21810 has been deleted. For external rib fixation, use 21899)◀

- **21811** Open treatment of rib fracture(s) with internal fixation, includes thoroscopic visualization when performed, unilateral; 1-3 ribs

- ▶ (For bilateral procedure, report 21811 with modifier 50)◀

- **21812** 4-6 ribs

- ▶ (For bilateral procedure, report 21812 with modifier 50)◀

- **21813** 7 or more ribs

- ▶ (For bilateral procedure, report 21813 with modifier 50)◀

Coding Tip

Code selection of codes 21811-21813 is based on the number of fractured ribs treated with internal fixation (eg, open reduction and internal fixation) and not the number of fractured ribs.

Clinical Example (21811)

A 72-year-old female presents with multiple displaced fractures of ribs 5, 6, and 7 on the right side after a fall resulting in intractable pain and an inability to maintain adequate oxygenation. On post-injury day three, open reduction and internal fixation of the rib fractures is performed.

Description of Procedure (21811)

Make a small incision over the displaced rib, dividing the skin, subcutaneous tissue, and muscle and exposing the ribs. Deflate the lung with the dual lumen endotracheal tube. Place a thoracoscope through a small separate incision in the pleural cavity, and visualize the area of the fractured ribs. Make additional similar small skin incisions over the fracture sites as identified by thoroscopic visualization.

Identify and separate the intercostal nerve bundles. Using thoroscopic visualization, fit the drill guide and plate or splint to the rib overlying the fracture. Drill the screw holes for attachment of the plate or splint insertion in each fracture site of the rib. Secure the splint or plate to the rib with locking screws to fix the hardware in place over the fracture. Repeat this procedure at each rib and/or fracture site. Remove the thoracoscope, inflate the lung, and close the wounds in layers.

Clinical Example (21812)

A 55-year-old male involved in a high-speed motor vehicle crash suffers segmental fractures of ribs 5 through 9 on the left side resulting in severe pain, progressive atelectasis, and

continued on page 10

Diabetes Prevention Program

A new Category III code, effective January 1, 2016, will be used to report the services provided in a standardized diabetes prevention program (DPP) recognized by the Centers for Disease Control and Prevention (CDC). This article provides an overview of such programs, along with a clinical example of the typical patient and description of services.

- **0403T** Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day

A DPP is an evidence-based program that is designed to delay or prevent the participant's progression to type 2 diabetes. The standardized curricula recognized by the CDC are year-long behavior change interventions comprising at least 24 sessions delivered across the course of a year: typically delivered in 16 weekly hour-long sessions during the first six months of the year, followed by monthly hour-long sessions during the second six months. Participants are weighed at every session and work toward goals of more healthful eating, 150 minutes per week of physical activity, and $\geq 5\%$ -7% weight loss. The standardized program is facilitated by lifestyle coaches (*note that both licensed and non-licensed coaches can deliver this program*) and participants who collaboratively discuss and identify solutions to health and behavior challenges for type 2 diabetes risk reduction.

DPP curricula recognized by the CDC are consistent with the behavior change curriculum that was successfully utilized in multiple National Institutes of Health (NIH) funded randomized clinical trials, including the DPP Trial, the Diabetes Prevention Program Outcomes Study, and the Diabetes Education Prevention with Lifestyle Intervention offered at the YMCA (DEPLOY studies).^{1,2} In the original DPP Trial, the behavior change intervention significantly reduced the number of new cases of type 2 diabetes by 58% during the three-year trial period and 71% for adults aged 60 years or older. The DEPLOY studies and more than two dozen other translations of the original DPP Trial into community settings showed that non-licensed providers of the curriculum could produce outcomes similar to those of health professionals. Through the CDC's intensive efforts to expand the number of organizations delivering the diabetes prevention program over the past five years, the standardized program is increasingly utilized by participants around the country.¹

The growing body of evidence led the CDC to create the national DPP, which includes the CDC's Diabetes Prevention Recognition Program (DPRP) standards and operating procedures. The DPRP standards are based on a

defined curriculum, content and duration, program delivery standards, data collection, and clearly defined program performance criteria that organizations must achieve to be recognized by the CDC as delivering a high quality, effective diabetes prevention behavior change intervention.

The DPRP also makes it clear that standardized diabetes prevention programs are not merely weight-loss programs. Participants must qualify for these programs with specific eligibility criteria beyond being overweight. They must have laboratory blood test values or specific risk factors indicating a high risk for type 2 diabetes. Throughout the behavior change intervention, participants have access to a trained coach who must be able to successfully deliver the program. In many cases, the coach receives at least 20 hours of standardized training conducted by master trainers on curriculum delivery, including collection of weight data, physical activity, food journal review, evidence-based information that supports the intervention; behavior change strategies, such as cue control, portion size, handling negative thoughts, increasing physical activity, and maintaining progress, motivational interviewing, group facilitation techniques; and annual Health Insurance Portability and Accountability Act (HIPAA) certification. (Note: The DPRP does not set coach training standards. The requirement is that coaches must receive training to effectively deliver the program and it is the CDC-recognized organization's responsibility to assure this.)

Clinical Example (0403T)

A 55-year-old female participant has a body mass index (BMI) of 30 and an elevated glucose level on her recent fasting plasma glucose test, which indicates she is in the prediabetes range (between 100-125 mg/dL). She goes to a community center where she learns about the standardized diabetes prevention program (DPP) curriculum and enrolls in the program. She consents to the center's program to inform her physician that she's enrolled in the program and provide progress reports on her participation program outcomes.

Description of Procedure (0403T)

The participant receives type 2 diabetes preventive behavior change intervention education approximately weekly for 16 one-hour visits with a group of participants meeting the same qualification criteria (BMI 25+ and screening tests suggesting prediabetes). The standardized service includes education on healthy eating and nutrition, increasing moderate to vigorous physical activity to 150 minutes per week, and behavior change strategies on stress management, cues, stress, and problem solving. The participant tracks food intake and physical activities minutes

continued on page 10

Coding Update: Central Nervous System Assessments/Tests (96110, 96127)

For CPT 2015, new code 96127 was added to the series of codes 96101-96127 and code 96110 was revised. These codes are used to report services that are provided during the testing of cognitive function of the central nervous system and describe distinct services, which specify the use of standardized instruments (previously validated tests that are administered and scored in a consistent or “standard” manner).

Both codes may be reported for the administration and scoring of each respective standardized instrument and either code may be reported multiple times, as necessary, to represent the administration of multiple different instruments for an individual patient encounter. Possible scenarios include the use of one or more instruments administered to the same informant or the same instrument administered to one or more informants (eg, same instrument to assess attention-deficit/hyperactivity disorder (ADHD) administered to each of two caregivers to obtain two different impressions). The use of multiple instruments for brief assessment does not replace psychological testing and is not intended for diagnostic purposes. This article clarifies the similarities and differences between codes 96110 and 96127.

▲ **96110** Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument

▶(For an emotional/behavioral assessment, use 96127)◀

● **96127** Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

▶(For developmental screening, use 96110)◀

Reporting Code 96110

The primary focus of the screening described by code 96110 is the early identification of patients who need further assessment of one or more areas of their developmental skills. The following are some of the developmental areas

the provider may assess based on documentation of the standardized instrument:

- Receptive or expressive and pragmatic language abilities
- Cognitive areas (eg, attention, memory, executive functions)
- Fine and gross motor skills
- Social interaction

Code 96110 may be reported whenever the screening is performed whether at specified health maintenance visits or at a clinical encounter in which the medical provider, parent/guardian, or patient has concerns. Appropriate encounters would include outpatient preventive medicine services, consultations, or new or established patient visits. These services may be performed in both an inpatient and outpatient settings.

Reporting Code 96127

New code 96127 describes the administration of a standardized behavioral and emotional assessment instrument, which serves as a mechanism to identify and/or measure emotional/behavioral symptom presence or severity. The assessment is not diagnostic of a specific condition or disorder, however, it may indicate the need for in-depth assessment or further intervention. Examples of assessment instruments include an ADHD rating scale or an anxiety or depression rating scale or inventory. These scales may be used over periods of time to assess response management.

Clinical Example (96127)

An 8-year-old male presents with a history of short attention span, inability to sit through a meal at home, and impulsive comments and actions. He has a six-month history of irritability, angry outbursts, and refusal to cooperate at home and in his school classroom. A parent version of a behavior assessment system for children is administered to his mother and scored. The medical provider explains the results to the mother and notes the results in the medical record. A teacher’s version of the behavioral assessment tool is sent to the child’s teacher for

continued on page 11

Coding Brief: Injection of Contrast for Knee Arthrography (27370)

Prior to the October 2013 CPT Editorial Panel meeting, the Relativity Assessment Workgroup of the American Medical Association/Specialty Society Relative Update Committee and the Centers for Medicare and Medicaid Services identified CPT code 27370 as a high volume growth—service that requires a review of physician work and practice expense inputs. The involved specialty societies submitted a code-change proposal (CCP) to address the high growth of this code. The CPT Editorial Panel then approved editorial revisions to the descriptor to clarify that the correct use of code 27370 is only to describe the injection of contrast into the knee joint space for arthrography. Code 27370 should not be used to report any other injection or aspiration procedure, such as knee arthrocentesis or aspiration (code 20610 or 20611), or any other service or procedure besides injection of contrast for knee arthrography (code 73580).

▲ 27370 Injection of contrast for knee arthrography

▶(For radiological supervision and interpretation, use 73580. Do not report 77002 in conjunction with 73580)

▶(Do not report 27370 in conjunction with 20610, 20611, 29871)◀

▶(For arthrocentesis of the knee or injection other than contrast, see 20610, 20611)◀

▶(For arthroscopic lavage and drainage of the knee, use 29871)◀

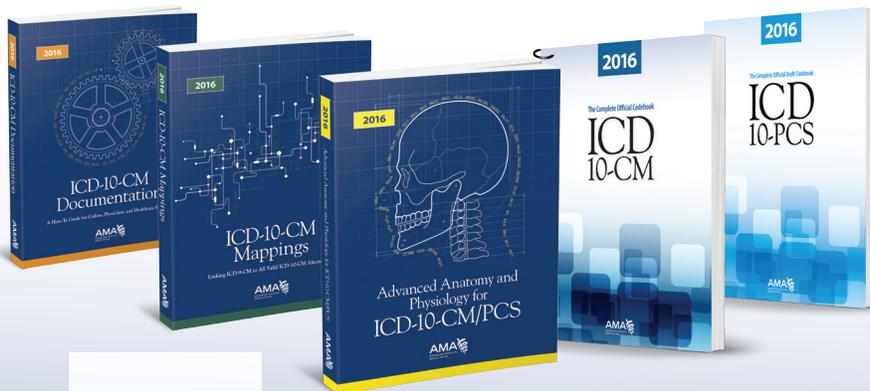
Coding Tip

When a computed tomography (CT) or magnetic resonance imaging (MRI) arthrography procedure is performed, it is appropriate to report one of the appropriate codes for the specific injection procedure (21116, 23350, 24220, 25246, 27093, 27095, 27096, 27370, or 27648), fluoroscopic guidance code (77002), and one of the appropriate 70000 series CT or MRI arthrography imaging codes (70336, 73201, 73222, or 73722).◆

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ICD-10-CM Case Scenario

A 53-year-old female is seen in a follow-up for chronic hypoxic respiratory failure, pulmonary heart disease, and hypertensive heart disease. She has been experiencing ongoing shortness of breath and swelling of the lower leg. A recent computed tomographic (CT) scan demonstrates emphysematous interstitial lung disease. In addition, predominantly peripheral and basilar ground glass and reticular opacities are unchanged from a prior CT scan of the chest. Currently, the patient is taking furosemide, spironolactone, valsartan, bisacodyl, sucralfate, amlodipine, and metoprolol succinate.

Examination: Blood pressure = 145/92 mm Hg; heart rate = 98 bpm [beats per minute]

Assessment: Uncontrolled pulmonary heart disease; hypertensive heart disease; congestive heart failure; scleroderma; and interstitial lung disease.

Code Assignment

In addition to the CPT code for the appropriate evaluation and management (E/M) level of service, the following *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM) codes would be reported for this case scenario.

- I27.9 Pulmonary heart disease, unspecified
- I11.0 Hypertensive heart disease with heart failure
- I50.9 Heart failure, unspecified
- M34.9 Systemic sclerosis, unspecified (Scleroderma)
- J84.9 Interstitial pulmonary disease, unspecified

Rationale

In the clinical example provided in this article, the patient's condition is documented as "hypertensive heart disease with congestive heart failure." The documenta-

tion indicates that the patient presents for a follow-up of her chronic hypoxic respiratory failure, pulmonary hypertension, hypertensive heart disease, scleroderma, and interstitial lung disease. Based on a recent CT scan, the patient was diagnosed with interstitial lung disease. Because of the interrelationship of hypertension and other hypertensive conditions, the coder must pay careful attention to instructional notations in both the Alphabetic Index and the Tabular List to ensure proper coding. When coding for other respiratory diseases that affects the interstitium, ICD-10-CM provides the following block of categories, as listed in the Tabular List:

- J80 Acute respiratory distress syndrome
- J81 Pulmonary edema
- J82 Pulmonary eosinophilia, not elsewhere classified
- J84 Other interstitial pulmonary diseases

Note that J84.9 is the complete code for unspecified interstitial pulmonary disease. The ICD-10-CM Official Guidelines for Coding and Reporting provide the following information regarding the level of detail in coding:

Diagnosis codes are to be used and reported at their highest number of characters available.

ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail.

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.◆

Frequently Asked Questions

Surgery: Cardiovascular System

Question: May code 36471 be reported with code 76942?

Answer: Yes, code 36471, *Injection of sclerosing solution; Injection of sclerosing solution; multiple veins, same leg*, may be reported with code 76942, *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*. Note that code 76942 should be reported only once per session, even though multiple injections of sclerosing agents may be performed in the same vein and/or its tributaries and includes visualization of all vein(s) being injected and venous outflow, if performed. Ultrasound guidance procedures require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized.

Surgery: Hemic and Lymphatic Systems

Question: What CPT code should be reported for the treatment of a microcystic lymphatic malformation in the neck that is treated by the placement of multiple angiocaths into the cystic components and injection of alcohol with removal of the catheters after 10 minutes?

Answer: CPT code 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)*, should be reported to describe this treatment of a microcystic lymphatic malformation.

Surgery: Nervous System

Question: What is the appropriate code to report for hand digital nerve repair/reconstruction with 2-cm nerve allograft? A nerve graft is used but not harvested.

Answer: The correct code to report is 64999, *Unlisted procedure, nervous system*. Code 64890, *Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length*, would not be appropriate to report as this code refers to a nerve **autograft** and not a commercially available allograft. In addition, code 64890 includes harvesting the nerve graft, which is significantly more work than using a commercial, off-the-shelf allograft for the nerve repair/reconstruction. Code 64910, *Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve*, would

also not be appropriate because a synthetic conduit or vein allograft is not a **nerve** allograft.

When reporting an unlisted code to describe a procedure or service, it may be necessary to submit supporting documentation (eg, procedure report) along with the claim to provide an adequate description of the nature, extent, need for the procedure, as well as the time, effort, and equipment necessary to provide the service.

Radiology: Diagnostic Ultrasound

Question: A patient is taken to the operating room (OR) for the creation of a left-sided radiocephalic arteriovenous (AV) fistula. After anesthesia induction, the surgeon performs a left upper extremity ultrasound, which demonstrates the cephalic vein is adequate for creating a primary fistula. The surgeon proceeds with the creation of the AV fistula (code 36821). Should code 76998 be reported because ultrasound guidance was used prior to incision?

Answer: No, it is not appropriate to report code 76998, *Ultrasound guidance, intra-operative*, for the ultrasound guidance used to identify which vein(s) are suitable for use in surgical construction of an arteriovenous fistula. If there is prior vein mapping by ultrasound or angiography for which the procedure was scheduled and the ultrasound is used to identify the vein and mark the skin for incision, then no additional code is reported as this is inherent to code 36821, *Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)*. Alternatively, if there has been no prior vein mapping and the superficial veins are imaged in the extremity to identify vein(s) suitable for the creation of an arteriovenous fistula, code 93971, *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study*, may be reported in addition to 36821 if images are saved and a report documented.

Medicine: Neurology and Neuromuscular Procedures

Question: Is it appropriate to report code 96002 (and 96004, if applicable) for static surface electromyography (sEMG)?

Answer: It is not appropriate to report code 96002, *Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles* or code 96004, *Review and interpretation by physician or other qualified healthcare professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and*

continued on page 11

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Reserve your seat at the coding industry's premier coding and reimbursement event. Meet and learn directly from the experts about CPT®, the Resource-Based Relative Value Scale (RBRVS), and Medicare. Ensure accurate and efficient claims submission in 2016.

Conference Location

The site for this year's CPT® and RBRVS 2016 Annual Symposium (Symposium) is the Chicago Marriott Downtown Magnificent Mile, located at 540 North Michigan Avenue, Chicago, IL 60611.

Day and Time: Wednesday, Thursday, and Friday, November 18-20, 2015

The American Medical Association (AMA) invites you to join hundreds of your colleagues in meeting and learning from the experts on CPT®, RBRVS, and Medicare payment policy. Symposium faculty includes representatives from the CPT Editorial Panel, CPT Advisory Committee, AMA/ Specialty Society Relative Value Scale (RVS) Update Committee (RUC), and Centers for Medicare & Medicaid Services (CMS) and Contractor Medical Directors (CMDs). Each faculty member will discuss in detail many of the significant changes to the CPT® 2016 codes and descriptors, as well as the 2016 payment policy and relative value unit (RVU) changes to the Medicare physician payment schedule. Topics discussed will include:

- Medicare Physician Payment Schedule 2016 Changes and Beyond
- Evaluation and Management and Other Miscellaneous Services
- Interventional Radiology
- Cardiovascular Procedures
- General Surgery
- Ophthalmology

- Molecular Pathology
- Pathology
- Otorhinolaryngology
- Radiology
- Radiation Oncology
- Neurological Surgery
- Pain Medicine and Anesthesia
- Gastroenterology

Revisions to CPT, Adjustments to RBRVS, and Coverage Changes

Sessions are scheduled to clarify and explain major changes in CPT® codes and descriptors and the Medicare physician payment schedule for 2016. Each presentation will review the development of coding policy, highlighting changes from the point when service description was developed or edited by the CPT Editorial Panel through its evaluation by RUC. Faculty presenters will also explain how CMS will implement payment policies and how CMDs will cover and reimburse for services in 2016.

Emerging Issues

Topics relevant to physician practices, which have the potential to influence future coding procedure and policy, will be selected for review and discussion. In addition, the Symposium will provide insightful coding guidelines and strategies to help you ensure accurate and efficient claims submission.

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CPT Coding for Rib Fracture Care, continued from page 3

enlarging hemothorax. Open reduction and internal fixation of the rib fractures is performed.

Description of Procedure (21812)

Make a small incision over the displaced rib, dividing the skin, subcutaneous tissue, and muscle and exposing the ribs. Deflate the lung with the dual lumen endotracheal tube. Place a thoracoscope through a small separate incision in the pleural cavity, and visualize the area of the fractured ribs. Make additional similar small skin incisions over the fracture sites as identified by thoroscopic visualization.

Identify and separate the intercostal nerve bundles. Using thoroscopic visualization, fit the drill guide and plate or splint to the rib overlying the fracture. Drill the screw holes for attachment of the plate or splint insertion in each fracture site of the rib. Secure the splint or plate to the rib with locking screws to fix the hardware in place over the fracture. Repeat this procedure at each rib and/or fracture site. Remove the thoracoscope, inflate the lung, and close the wounds in layers.

Clinical Example (21813)

A 24-year-old pedestrian is struck by a car and suffers multiple left-side rib fractures with obvious flail chest. A

three-dimensional (3D) CT chest reconstruction confirms comminuted and displaced fractures of ribs 2 through 10, with flail segments of ribs 4 through 8 and significant chest wall collapse. Open reduction and internal fixation of the rib fractures is performed.

Description of Procedure (21813)

Make a small incision over the displaced rib, dividing the skin, subcutaneous tissue, and muscle and exposing the ribs. Deflate the lung with the dual lumen endotracheal tube. Place a thoracoscope through a small separate incision in the pleural cavity, and visualize the area of the fractured ribs. Make additional similar small skin incisions over the fracture sites as identified by thoroscopic visualization.

Identify and separate the intercostal nerve bundles. Using thoroscopic visualization, fit the drill guide and plate or splint to the rib overlying the fracture.

Drill the screw holes for attachment of the plate or splint insertion in each fracture site of the rib. Secure the splint or plate to the rib with locking screws to fix the hardware in place over the fracture. Repeat this procedure at each rib and/or fracture site. Remove the thoracoscope, inflate the lung, and close the wounds in layers.◆

Diabetes Prevention Program, continued from page 4

as he or she works to reduce body weight by 5% to 7% in order to prevent or delay the onset of type 2 diabetes.

At the conclusion of the 16 weekly sessions, the participant continues to attend up to eight monthly one-hour group sessions in order to maintain weight loss achieved and sustain behavior changes.

The physician receives a progress report on his or her patient's progress at visits 8 and 16, which contains the number of visits, weight loss at each point in time, minutes of physical activity reported, and completion level of food journals for documentation in the patient's medical record.

Coding Tip

The provider of the DPP may report one unit of the CPT code for each 60-minute session [or equivalent]).

Rationale

The number of different codes previously used to report diabetes prevention program reflects the rationale for the

creation of the new Category III code 0430T. This is a distinct behavioral intervention that is based on a standardized curriculum to address risk factors related to prediabetes, which is designed to prevent the progression of prediabetes to type 2 diabetes. It is offered in a nontraditional care setting, provided by trained peer-facilitators, and this new code will allow for preventive health service tracking, and payment for this type of low-cost behavior change intervention may be helpful to the approximately 86 million Americans aged 20 or older who have prediabetes.◆

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3. Ali MK, Echouffo-Tcheugui JB, Williamson DF. How effective were lifestyle interventions in real-world settings that were modeled on the Diabetes Prevention Program? *Health Affairs.* 2012; 31(1): 67-75.

Coding Update: Central Nervous System Assessments/Tests, continued from page 5

additional input, and a follow-up appointment is scheduled to review the teacher's responses and discuss diagnosis and treatment options.

Description of Procedure (96127)

The administration and scoring of the brief standardized behavioral/emotional assessment instrument is performed.

The purpose of the instrument is explained to the patient and/or family member and the response choices are explained. When the brief instrument is completed, the instrument is scored, and the results are delivered to the physician or other qualified healthcare professional.◆

Frequently Asked Questions, continued from page 8

dynamic fine wire electromyography, with written report, for sEMG (muscles at rest) because both of these codes refer to measurements related to motion. The correct code to report for sEMG is 95999, Unlisted neurological or neuro-muscular diagnostic procedure.

When reporting an unlisted code to describe a procedure or service, it may be necessary to submit supporting documentation (eg, a procedure report) along with the claim to provide an adequate description of the nature, extent, and need for the procedure, as well as the time, effort, and equipment necessary to provide the service.

Modifiers

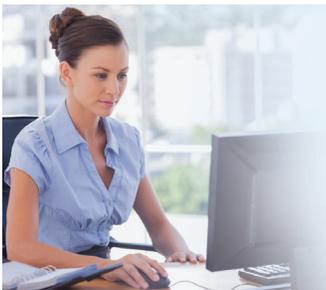
Question: *How should a bilateral procedure be reported when the code description only includes the word "unilateral," and there are no bilateral codes? For example, when an ultrasound of both breasts is performed, code 76641, Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete, is reported; however,*

should the procedure be reported with modifier 50 as single-line item or as separate line items with an anatomic modifier to indicate each side?

Answer: If the term "unilateral" is included in the code description and there is no code for "bilateral" work, modifier 50, *Bilateral procedure*, should be appended to the code, if anatomically appropriate.

From a coding perspective, unless otherwise noted in the CPT code set, bilateral procedures performed on the same operative session should be identified by adding modifier 50 to the appropriate CPT code. CPT coding guidelines recommend using a single-line entry with modifier 50 appended to the appropriate unilateral code as a one-line entry on the claim form, with a "1" in the units-box to indicate that the procedure was performed bilaterally.

Although this reporting method reflects the recommendation for reporting CPT codes, third-party payers may request that these services to be reported differently.◆



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