2013 CPT Changes as of October 2012

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Some information is starting to come out regarding changes that will be taking place for 2013 in respect to CPT codes. There are many changes in the EM section, but you will find that the majority of those changes/revisions are just related to adding the term ‘other qualified healthcare professional.’

In the Integ section there were also some changes with the revision of code 15740 - Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel. With this change there was a guideline change also:

“Code 15740 describes a cutaneous flap, transposed into a nearby but not immediately adjacent defect, with a pedicle that incorporates an anatomically named axial vessel into its design. For random island flaps, V-Y subcutaneous flaps, advancement flaps, and other flaps, from adjacent areas without clearly defined anatomically named axial vessels see 14000-14302.”

We finally will have two new codes for revision of total shoulder and two new codes for revision of total elbow prosthesis. The shoulder codes will read:

“23473 Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component” and “23474 Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component.”

The elbow codes will read:

“24370 Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component” and “24371 Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component.”

Having these four new codes will help now with the correct way to report these revisions. There are now guidelines under the removal of implant codes:

“Do not report 23331-23332 in conjunction with 23473, 23474 if a prosthesis [i.e. humeral and/or glenoid component(s)] is being removed and replaced in the same shoulder.”
Revisions to the spinal instrumentation and grafting section include adding the new CPT codes for arthrodesis. Also, a new code, 22586 Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace – with (Do not report 22586 in conjunction with 20930-20938, 22840, 22848, 72275, 77002, 77003, 77011, 77012). If you do the L4/5 (0309T Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft, when performed, lumbar, L4-L5 interspace (List separately in addition to code for primary procedure)) level you will need to use the new Category III code for this “add on” level.

Some changes in the radiology section you will find for 2013. They are finally removing the reference to the types of views for cervical spine imaging, now the codes will just have the number of views:

- 72040 Radiologic exam, spine, cervical; 3 views or less
- 72050 Radiologic exam, spine, cervical; 4 or 5 views
- 72052 Radiologic exam, spine, cervical; 6 or more views

In the Medicine section under the Electrodiagnostic testing you will find that CPT/AMA did some further deletions and additions relating to NCS. The existing codes 95900-95904 will be deleted for 2013 and replaced with seven new codes. You will no longer have to know if these are sensory, with F waves or without F waves. Now you will select the code based on how many studies are being done. Code 95905 will still be available in 2013 for those NC-Stat devices, but many Medicare policies currently state that you can’t report this code with any other NCS codes. You will need to check with your payers for 2013 to see if that will still be the issue. It will also be interesting to see what value is placed on these new NCS codes. Here are the codes and their descriptions:

- 95907 Nerve conduction studies; 1-2 studies
- 95908 Nerve conduction studies; 3-4 studies
- 95909 Nerve conduction studies; 5-6 studies
- 95910 Nerve conduction studies; 7-8 studies
- 95911 Nerve conduction studies; 9-10 studies
- 95912 Nerve conduction studies; 11-12 studies
- 95913 Nerve conduction studies; 13 or more studies

Another change in this section is the code 95920 intraoperative monitoring, which will be deleted in 2013. It will be replaced with two codes relating to intraoperative monitoring: one will be used when the monitoring is done while in the OR and the other will be for monitoring when ‘outside the OR’. Many Medicare payers/carriers have had internal policies regarding the ‘off-site’ monitoring so make sure you check those out as well.
95940 - Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)

95941 - Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)

Chemodenervation changes are also in the 2013 CPT manual. First some further guidance:

“Do not report a code labeled as destruction when using therapies that are not destructive of the target nerve (e.g., pulsed radiofrequency), use 64999. For codes labeled as chemodenervation, the supply of the chemodenervation agent is reported separately”

And also the following code changes:

64612 - Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, *unilateral* (e.g., for blepharospasm, hemifacial spasm). They made this code ‘unilateral’ – Modifier 50 allowed

64613 – Report ONCE per session – DO NOT use modifier 50

64614 Chemodenervation of muscle(s); extremity and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis). They removed plural extremities from this code and you can only report ONCE per session.

(New code) 64615 Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (e.g., for chronic migraine). Can only report ONCE per session and do not report 64615 in conjunction with 64612-64614