AAPC

HEALTHCON

CPT Assistant and How to Use It

Date: 05/08/2017
Time: 9:45 AM – 11:00 AM

Mark S. Synovec, MD
CPT Editorial Panel Vice-Chair
CPT Assistant Executive Editor & Editorial Board Chair

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CPT Assistant & How to Use It

During this session we will discuss how CPT Assistant articles are created and how to effectively use them to increase coding accuracy. We will review examples of coding gray areas and how CPT Assistant provides valuable information to clarify proper code use.

Topics

1. *CPT-A* History
2. CPT Assistant (*CPT-A*) Principles
3. *CPT-A* Process
4. *CPT-A* Exemplars

CPT-A History

Pre-CPT Assistant

1933 New York Academy of Medicine published *Standard Classification of the Nomenclature of Disease.*

1963-81 AMA publishes *Current Medical Terminology*, a system of preferred and supplementary terms and descriptors for diseases.

1966 AMA publishes first edition of *Current Procedural Terminology.*

1970 AMA-*CPT* second edition published, beginning current 5 digit format.

CPT-A History

Pre-CPT Assistant

1973 AMA-*CPT* third edition published.

1977 AMA-*CPT* fourth edition published, begin quarterly updates.

1983 AMA and HCFA agreed to use *CPT* as a part of the Common Procedure Coding System (HCPCS) in federal programs to report physician services.

1984 Annual publication of *CPT* replaces quarterly updates.

CPT-A History

1991-1995

The inaugural issue of *CPT Assistant* was published in the winter of 1990/1991. The newsletter was a quarterly publication. The goal was to create a newsletter that will serve as the authoritative source on CPT coding from the American Medical Association (AMA).

CPT-A History

1996

CPT Assistant became a monthly publication in response to an increased demand from readership. During the same year, the archive of *CPT Assistant* content was made available in CD-ROM format. In addition, the content of *CPT Assistant* was also made available for licensing.

CPT-A History

2004

At the House of Delegates' annual meeting, the House adopted a resolution that called on the AMA to study the feasibility of developing a national standard for the utilization of codes, code combination, and modifiers that is consistent with all CPT codes, guidelines, and conventions.

This was the genesis for establishing the *CPT Assistant* Editorial Board (EB).

CPT-A History

2007

The AMA created an Editorial Board (EB) for *CPT Assistant* to:

- Formally involve physicians, public and/or private payers, coding professionals, and other CPT stakeholders to review the publication's coding content.
- To ensure published content is based on input from public and private payers, physician organizations, nonphysician health care professional organizations, and other CPT stakeholders.
- To reinforce *CPT Assistant* as the definitive and authoritative source for CPT coding questions.

CPT-A History

2009

CPT Assistant went online in the AMA's Online Code Manager

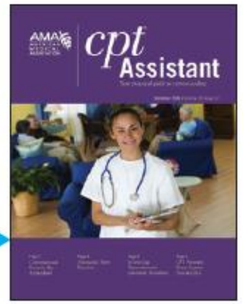
2010

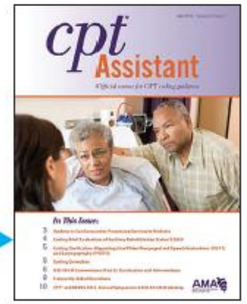
The *CPT Assistant* Bylaws and mission statement were adopted by the Editorial Board

2016

CPT Assistant content became available on the AMA's CPT smart phone App

CPT-A History





1990 | 1991 | 2000 | 2003 | 2005 | 2008 | 2016 | 2020

CPT-A Principles

Mission Statement

The mission of the Board is to advance the accurate and consistent use of the *CPT*® code set by establishing a consensus among stakeholders in order to provide clear and unambiguous interpretation of the *CPT*® code set. Through the efforts of the Board, the *CPT*® *Assistant* newsletter *(CPT*® *Assistant)* will convey proper coding and reporting of procedures and services described by the *Current Procedural Terminology* (CPT®*)* code set.

CPT-A Principles

Goals

The complexity of the CPT® code set and the potential for differences in interpretation between payers and providers necessitated the AMA to create a formal Editorial Board for *CPT® Assistant* consisting of payers, providers, panel members, CPT® Advisory Committee members, Health Care Professionals Advisory Committee (“HCPAC”) members, hospitals, and AMA staff to address issues.

CPT-A Principles

The Board fulfills its mission through the pursuit of the following specific goals to:

- Achieve a high-quality *CPT® Assistant* publication;
- Provide a vehicle for reducing conflict between professional and institutional providers, third-party payers, specialty societies, and other health care professionals in the interpretation of CPT® coding; and
- Promote consistent methods of review and authorship of all content published in the *CPT® Assistant* newsletter

CPT-A Editorial Board

Appointed Board Members

Chairperson

(The Vice Chairperson of the Panel)

Mark S. Synovec, MD

Secretary

Marie L. Mindeman,

(Managing Editor of CPT Assistant)

Elected Board Members

Two Current or Former CPT Editorial Panel Representatives

(one surgical/one nonsurgical)

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Joel F. Bradley, MD

Two CPT Advisory Committee Representatives

Timothy Swan MD (SIRS)

Sean P. Roddy, MD (SVS)

One HCPAC Representative

Ira H. Kraus, DPM (APMA)

Contractor Medical Director (CMD) Representative

Olatokunbo Awodele, MD

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AMA RVS/RUC Representative

Thomas Weida, MD, FAAFP

AMA Representative

Karen O'Hara, BS, CCS-P

(Manager CPT content and development)

CPT-A Staff

- **Managing Editor, Content Quality Editor & Editorial Assistant**
  - Marie Mindeman, Danielle Pavloski, BS, RHIT, CCS-P & Rejina L. Young
- **Contributing Staff**
  - Andrei Besleaga, RHIT; Janette Meggs, RHIA; Danielle Pavloski, RHIT, CCS-P; Arletrice Watkins, MHA, RHIA; Rejina Young
- **Development and Production Staff**
  - Nancy Baker (Manager, Book and Product Development and Production), Lisa Chin-Johnson (Senior Developmental Editor), Mary Ann Albanese (Production Specialist)

CPT-A Process

WHO REQUESTS CPT ASSISTANT ARTICLES?

- CPT Editorial Panel
- CPT EP Executive Committee
- Relative Value Update Committee (RUC)
- Specialty Societies
- Symposium Attendees
- CPT Assistant Subscribers
- Third Party Payers
- CPT Network Subscribers

CPT-A Process

WHO READS CPT ASSISTANT ARTICLES?

- Medical Coders (mostly AAPC members)
- AMA Members
- Physicians (more specialists than PCPs)
- Third Party Payers
- Consultants
- Outpatient Clinics

CPT-A Process

Article Categories

Featured Article
Articles with up-to-date information on codes and trends in the coding industry

Coding Clarification
Articles clarifying coding dilemmas

Coding Brief
Brief coding updates

Then and Now
Revisions, updates and/or reiterations of long-standing information

Frequently Asked Questions
Answers to frequently asked questions submitted through the CPT Network

Featured Article

March 2017 / Volume 27 Issue 3

cpt® Assistant

Official source for CPT coding guidance

In This Issue:

AMA AMERICAN MEDICAL ASSOCIATION

Coding for Endovascular Procedures for Dialysis Access

Nine new codes for endovascular procedures for dialysis access (36901-36909) were added, and four codes (36147, 36148, 36870, 75791) were deleted in the Current Procedural Terminology (CPT®) 2017 code set. These changes were made in response to a request from the Relative Value Scale Update Committee (RUC) Relativity Assessment Workgroup (RAW) to review the existing codes based on a screen identifying codes frequently reported together as well as a screen identifying rapidly growing services. The new codes bundle services that are commonly performed together. The *CPT® 2017* codebook also includes extensive introductory language and parentheticals to help guide the use of this code set. This article discusses these changes and provides guidance on the appropriate use of these new codes.

An understanding of the anatomy of the dialysis circuit is requisite to proper coding of endovascular procedures within the dialysis circuit. These anatomic definitions are as follows:

Dialysis circuit: The arteriovenous (AV) dialysis circuit is the vascular channel used to perform hemodialysis. For coding purposes, the dialysis circuit begins at the arterial anastomosis and extends to the right atrium. The circuit may be created using either an arterial-venous anastomosis, known as an arteriovenous fistula (AVF), or a prosthetic graft placed between an artery and vein, known as an arteriovenous graft (AVG). The dialysis circuit is comprised of two segments, termed the (1) peripheral dialysis segment and (2) central dialysis segment.

Peripheral dialysis segment: The peripheral dialysis segment is the portion of the dialysis circuit that begins at the arterial anastomosis and extends to the central dialysis segment. In the upper extremity, the peripheral dialysis segment extends through the axillary vein (or entire cephalic vein in the case of cephalic venous outflow). In the lower extremity, the peripheral dialysis segment extends through the common femoral vein. The peripheral dialysis segment includes the historic "peri-anastomotic region."

Central dialysis segment: The central dialysis segment includes all draining veins central to the peripheral dialysis segment. In the upper extremity, the central dialysis segment includes the veins central to the axillary and cephalic veins, including the subclavian and innominate veins through the superior vena cava. In the lower extremity, the central dialysis segment includes the veins central to the common femoral vein, including the external iliac and common iliac veins through the inferior vena cava. In some cases, the main central veins may be occluded, but the access may continue to function because of the development of large collaterals in the neck and chest, in which case these collaterals are the "central dialysis segment."

Peri-anastomotic region: An historic term referring to the region of a dialysis circuit near the arterial anastomosis encompassing a short segment of the parent artery, the anastomosis, and a short segment of the dialysis circuit immediately adjacent to the anastomosis. The peri-anastomotic region is included within the peripheral segment of the dialysis circuit, and all interventions of the peri-anastomotic region are reported as interventions of the peripheral dialysis segment.

Performed through dialysis circuit: Any diagnostic study or therapeutic intervention within the dialysis circuit that is performed through a direct percutaneous access to the dialysis circuit.

Codes 36901-36909 bundle the typical surgical procedure(s) with related radiological supervision and interpretation (RS&I) services. Each of these codes includes direct percutaneous access(es) to the fistula (ie, punctures), catheterizations, catheter manipulations, roadmapping, imaging guidance, contrast injections, completion angiography, and closure of the punctures by any method. The codes are built on a progressive hierarchy, with lesser intensive services included in codes describing higher intensive services. For base codes 36901-36906, diagnostic angiography of the entire dialysis circuit is included, when performed. When interventions are performed, the code that describes the highest intensity service provided should be selected so that only one code is reported. For codes describing stent placement (36903, 36906), balloon angioplasty is included and is not separately reported, even if balloon angioplasty is performed on a separate lesion in the same dialysis segment.

Atypical access (eg, for upper extremity dialysis circuits—common femoral artery/vein, internal jugular vein, brachial artery) is not included in codes 36901-36906, and catheterizations from these locations may be separately reported using existing coding conventions. When separately reporting an atypical access, the medical justification(s) for why an atypical access was necessary to conduct the procedure must be documented, and the dialysis services (36901-36906) must be reported with modifier 52, *Reduced*

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Frequently Asked Questions

Frequently Asked Questions

Evaluation and Management: Case Management Services

Question: *Is it appropriate to report Current Procedural Terminology (CPT®) code 99363 for anticoagulant management, initial 90 days of therapy if the patient is admitted after those 90 days of therapy?*

Answer: It is appropriate to report code 99363, *Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)* in this scenario for the initial 90 days of outpatient/ambulatory treatment. However, usage of this code is inappropriate in relation to the subsequent hospitalization and outpatient care post hospitalization. This is because the procedure described by code 99363 is provided in the office or outpatient setting and is used for outpatient services only and because when anticoagulation therapy is initiated or continued in the inpatient or observation setting, a new period begins after discharge and is reported with 99364, *Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; anticoagulation management, each subsequent 90 days of therapy (must include a minimum of 3 INR measurements).*

If anticoagulant management ends with a final time period of less than 60 outpatient days (short-term), it is not to be reported with codes 99363 or 99364. Instead, individual anticoagulant management encounters should be reported with 99211, *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.* If an office or other outpatient visit occurs, it may be included in a more expansive evaluation and management (E/M) office or other outpatient visit code provided by the physician, but not both. Please note, third party payer policies may differ from CPT guidelines.

Surgery: Musculoskeletal System

Question: *What is the appropriate code to report the excision of a bony ossicle on the knee caused by Osgood-Schlatter disease?*

Answer: Currently, there is no specific CPT code that describes this procedure. Therefore, code 27599, *Unlisted procedure, femur or knee,* may be reported. When reporting an unlisted code to describe a procedure or service, it is necessary to submit supporting documentation (eg, procedure report) along with the claim to provide an adequate description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service.

Surgery: Respiratory System

Question: *What is the appropriate code to report for shaving/reduction of a patient's thyroid notch or Adam's apple (chondrolaryngoplasty)?*

Answer: Currently, there is no specific CPT code to report for shaving/reduction/partial removal of a patient's thyroid notch or Adam's apple (chondrolaryngoplasty). Although the procedure is commonly referred to as a "tracheal shave" it is performed on the thyroid cartilage notch, a laryngeal structure. The procedure is not performed on the trachea. The laryngoplasty family of codes (31580-31592, including 31551-31554) was revised in 2017 and none of these describes this service. Code 31599, *Unlisted procedure, larynx* would be the appropriate code to report. When reporting an unlisted code to describe a procedure or service, it will be necessary to submit supporting documentation (eg, procedure report) along with the claim to provide an adequate description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service.

Surgery: Digestive System

Question: *What is the appropriate code to report a heterotopic liver allotransplantation (leaving the recipient organ in place while transplanting a donor liver in a different [ectopic] location)?*

Answer: Code 47399, *Unlisted procedure, liver,* should be reported for heterotopic liver allotransplantation. In the past, code 47136 was used to report this procedure, but this code was deleted in the CPT 2016 code set due to low utilization. When reporting an unlisted code to describe a procedure or service, it will be necessary to submit supporting documentation (eg, procedure report) along with the claim to provide an adequate description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service.

Surgery: Male Genital System

Question: *The surgeon first performs an exploration to evaluate the position, size, and structural normality of undescended testis (54550). Then the surgeon proceeds to perform an orchiopexy via inguinal approach. Should the exploration (54550) and the definitive procedure (54640) both be reported?*

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Coding Update

Coding Update: Neurostimulators, Analysis-Programming

The Neurostimulators, Analysis-Programming subsection guidelines, which is related to criteria used to report simple or complex programming of neurostimulators, were revised in the Current Procedural Terminology (CPT®) 2016 code set. The revised guidelines clearly describe the intent of each code in this subsection and differentiate between "simple" vs "complex" programming procedures (ie, identifying three or fewer parameters for simple vs four or more for complex procedures). This coding update provides an overview of the 2016 changes.

95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

95971 simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

▲95972 complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

95974 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour

+95975 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

(Use 95975 in conjunction with 95974)

95978 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour

+95979 each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

(Use 95979 in conjunction with 95978)

95980 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming

95981 subsequent, without reprogramming

95982 subsequent, with reprogramming

Simple intraoperative or subsequent programming of the neurostimulator pulse generator/transmitter (95971) includes changes to three or fewer of the following parameters: rate; pulse amplitude; pulse duration; pulse frequency; eight or more electrode contacts; cycling; stimulation train duration; train spacing; number of programs; number of channels; alternating electrode polarities; dose time (stimulation parameters changing in time periods of minutes, including dose-lockout times); and more than one clinical feature (eg, rigidity, dyskinesia, tremor). On the other hand, complex intraoperative or subsequent programming (95972, 95974, 95975, 95978, and 95979) includes changes to more than three of the above. Codes 95974 and 95978, which are reported for the first hour of electronic analysis, requires the use of modifier 52 for analysis that is less than 31 minutes in duration.

In addition, code 95973 was identified by the American Medical Association/Specialty Society Relative Value

continued on page 11

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Then and Now

CPT Assistant THEN and NOW

As medical terminology and the performance of services and procedures change, so do the associated reporting methods. In this feature, we will regularly revisit previously published articles to correct, revise, update, and/or reiterate long-standing information.

Repair of Retinal Detachment

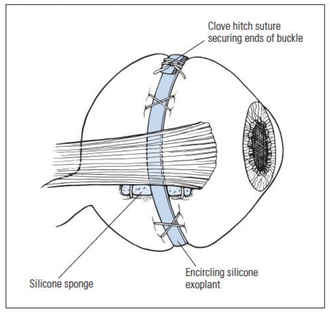
THEN

The following FAQ was published in the April 2009 issue of *CPT® Assistant* (p 9). Since then, revisions have been made for reporting retinal detachment repair in the Surgery: Posterior Segment subsection of the *Current Procedural Terminology* (CPT®) 2016 codebook, which now makes this FAQ obsolete.

Surgery: Eye and Ocular Adnexa (67112, 66940)

Question: *If a repair of retinal detachment is done by scleral buckling on a patient who has had a previous retinal detachment repair in the same eye, and an extracapsular lensectomy is performed during the same session, is it appropriate to report CPT codes 67112 and 66940? It should be noted that this was the patient's natural lens.*

Repair of Retinal Detachment



Source: *CPT Professional 2016*. Chicago: American Medical Association; 2015.

Answer: Yes, it is appropriate to report CPT code 67112, *Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques*, and CPT code 66940, *Removal of lens material; extracapsular (other than 66840, 66850, 66852), during the same session*. Code 66940 is subject to modifier 50 when the repair is performed bilaterally.

NOW

Code 67112 is deleted in the CPT 2016 code set as an obsolete procedure. It combined scleral buckling with an unspecified vitrectomy that could be more accurately reported with other more specific codes. In addition, codes 67101, 67105, 67107, 67108, and 67113 were revised to replace the phrase "with or without" with "including . . . when performed" to maintain CPT convention for consistent terminology.

▲67101 Repair of retinal detachment, 1 or more sessions; cryotherapy or diathermy, including drainage of subretinal fluid, when performed

▲67105 photocoagulation, including drainage of subretinal fluid, when performed

▲67107 Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid

▲67108 with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique

▲67110 by injection of air or other gas (eg, pneumatic retinopexy)

►(67112 has been deleted. To report, see 67107, 67108, 67110, 67113)◄

(For aspiration or drainage of subretinal or subchoroidal fluid, use 67015)

▲67113 Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens

Updated Question: *If a repair of retinal detachment is performed by scleral buckling on a patient who has had a previous retinal detachment repair in the same eye, and an extracapsular lensectomy is performed during the same session, what code(s) is reported? It should be noted that this was the patient's natural lens.*

Updated Answer: The correct code to report depends on whether vitrectomy was performed. If vitrectomy was performed, code 67108, *Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique*, would be reported. If vitrectomy was not performed, and only scleral buckling was performed, codes 67107, *Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid*, and 66940, *Removal of lens material; extracapsular (other than 66840, 66850, 66852)*, would be reported.◆

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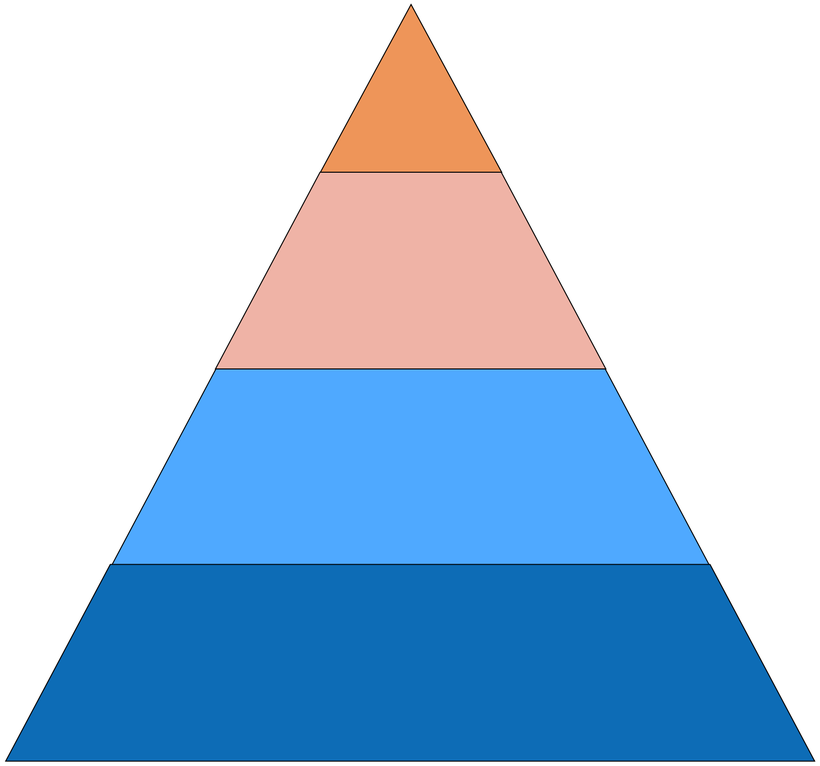
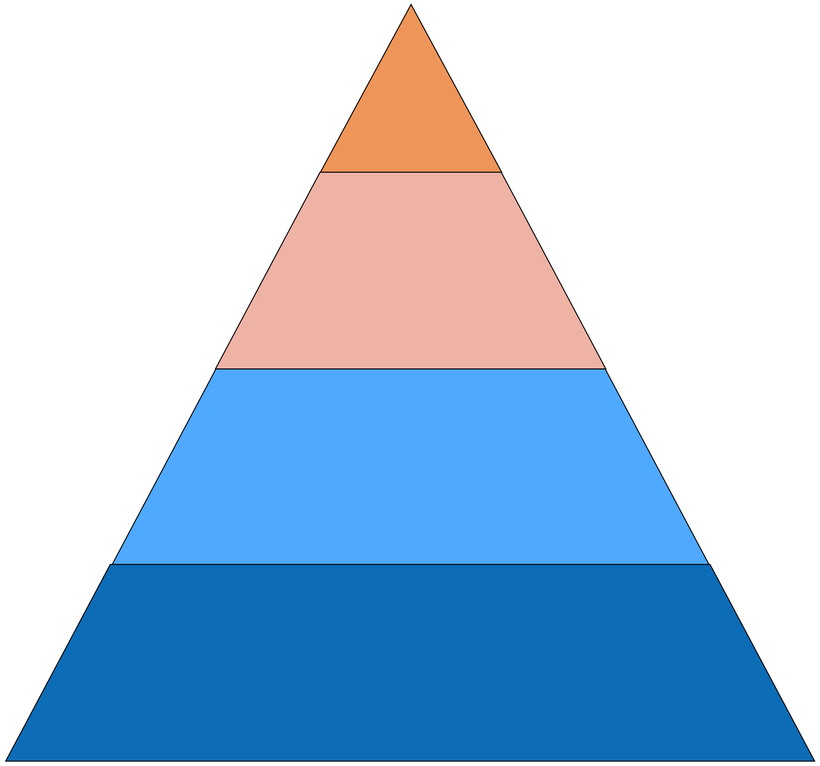
CPT-A Process



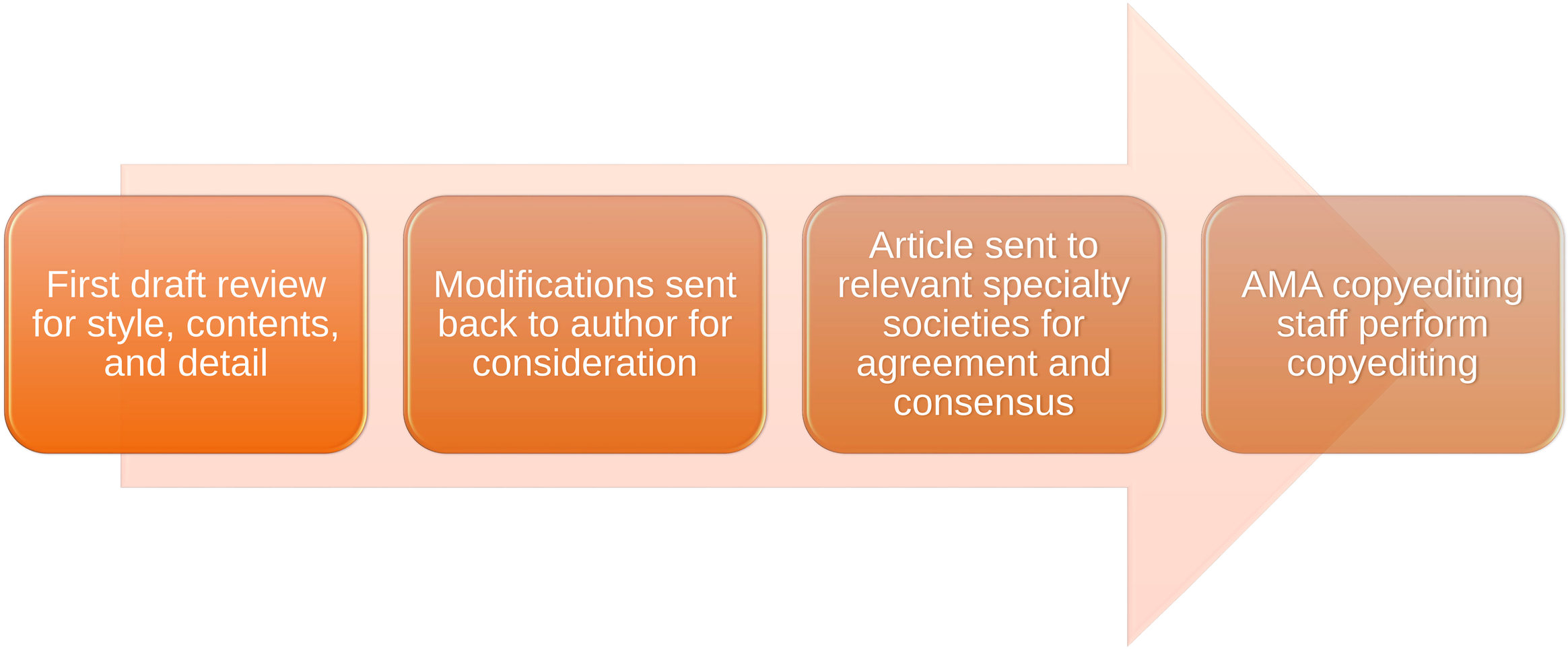
ARTICLE MANAGEMENT

CPT-A Process



- **Staff process**
- **Editorial board process**
- **Production process**

CPT-A Staff Process flow



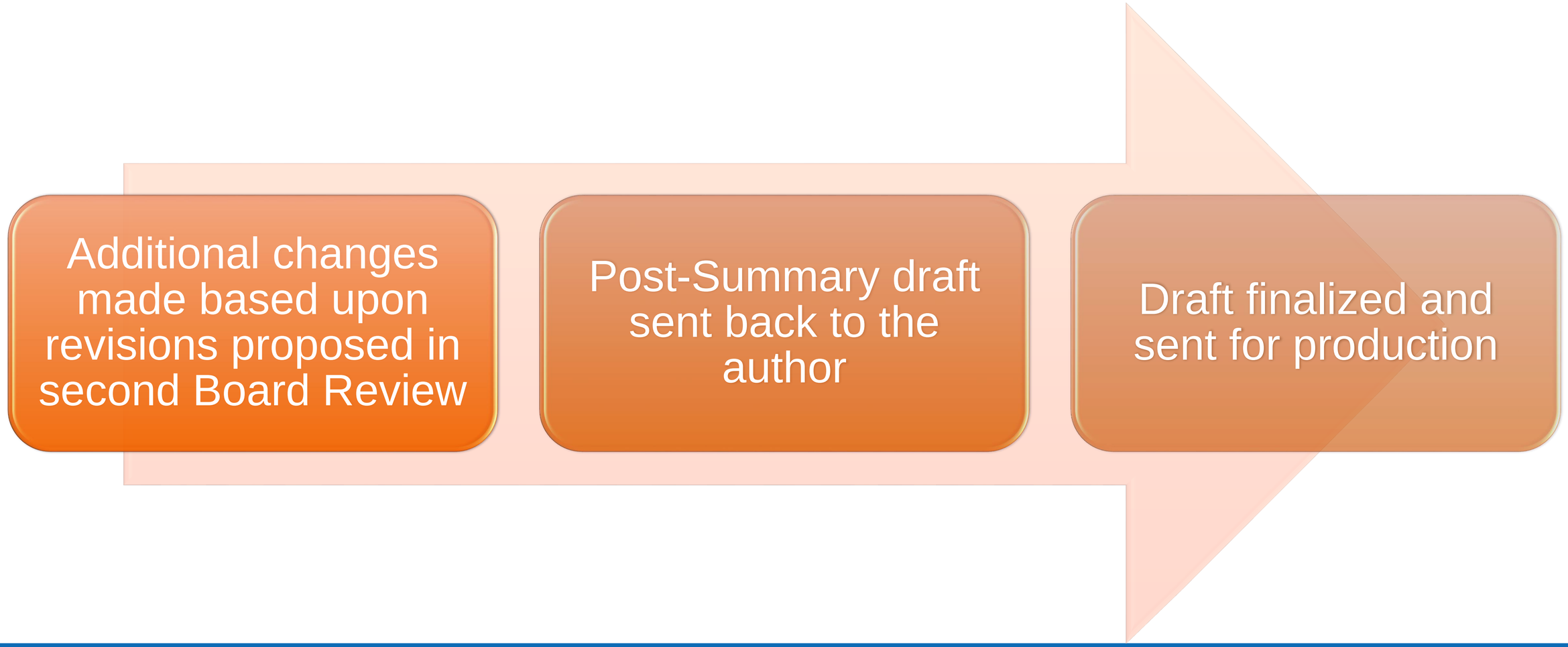
CPT-A Editorial Board Process Flow

Posted to collaboration web site for independent review by members of Editorial Board

Board member revisions sent back to staff
(2 week deadline)

Summary documents with all recommended revisions created, conflicts in comments resolved, and Summary Documents posted for Editorial Board second review

CPT-A Post-Summary Process Flow



CPT-A Timeline From Submission to Publication

Name:	2017 CPT Assistant newsletter, Volume 27					Meetings:	CPT RUC									DATES:	10/11/16							
Acq Editor:							Feb CPT Editorial Panel	2/9/17-2/11/17	New Orleans							Dev Editor:	Lisa Chin-Johnson							
Editor:	Danielle Pavloski						May CPT Editorial Panel	5/12/17-5/14/17	Chicago							Proj Spec:	Mary A. Albanese							
Editorial Asst:	Rejina Young						June CPT Editorial Panel	6/1/17-6/3/17	Boston															
Mktg Mgr:	Susan Jarrett						Sept CPT Editorial Panel	9/13/17-9/16/17	Chicago							Printer:	Darwill							
Design:	Mary Ann Albanese						CPT & RBRVS Symp	11/14/17-11/17/17	Chicago															
Int = internal; Ext= External																								
Desired mail date: 15th, or after, for every month for regular issues																								

Issue	Int/Ext AU Writes Articles--2 weeks	CPT Staff Review Articles --5 days	Int/Ext AU Incorp CPT Staff's Suggested Changes--2 days	Revised Articles for Specialty Review--2 weeks	Int/Ext AU Incorp Specialty-Reviewed Changes--3 days	Manuscript To DE for Copyediting & Tagging --5 days	Copyedited Msp fr DE to CPT Staff (for int/ext au review and to make changes etc)--3 days	Upload Approved & Revised Copyedited Articles for 1st Panel Review--2 weeks MUST INCLUDE 2 WEEKENDS	Download 1st Panel-Reviewed Articles for Int/Ext AU Incorp and Edits--1-2 days	Upload Revised Articles for 2nd Panel Review--7 days (MUST INCLUDE A WEEKEND)	Download 2nd Panel-Reviewed Articles (for int/ext au review and to make changes etc)--1-2 days	Synovec Review (must include a weekend)	Final Msp to DE for Comp -- 3 days	Manuscript to Design --2 days	1st Pass PDF to DE/CPT Staff--3 days	1st Pass Edits to DE fr CPT Staff--3 days	Final Pass PDF to DE/CPT Staff --2 days	Approve &/or CX for Final PDF to DE --1 days	CPT Staff (DP) Reviews & Approves Revised Final PDF for Printing	Designer uploads Approved PDF pages to Darwill	Final PDF to Knowlysis and Optum	PS (MAA) Approves Final Pges on Darwill InSite	Desired Mail Date	On OCM Date
														Distr memo due					(1 day)					
Jan-17	8/25/16	9/8/16	9/14/16	9/16/16	9/29/16	10/4/16	10/11/16	10/14/16	11/29/16	######	12/8/16	12/9/16	12/13/16	12/15/16	12/19/16	12/21/16	12/27/16	12/29/16	1/3/17	1/3/17	1/3/17	1/3/17	1/17/17	1/12/17
Actual						10/24/16	10/26/16						12/1/16	12/5/16	12/7/16									
Feb-17	10/19/16	11/2/16	11/9/16	#####	11/30/16	12/5/16	12/12/16	12/16/16	1/3/17	1/4/17	1/12/17	1/13/17	1/17/17	1/19/17	1/23/17	1/25/17	1/27/17	1/30/17	1/31/17	2/1/17	2/1/17	2/1/17	2/15/17	2/13/17
Actual						11/29/16	12/7/16																	
Mar-17	11/16/16	12/5/16	12/12/16	#####	1/3/16	1/6/16	1/13/16	1/18/17	1/31/17	2/1/17	2/9/17	2/10/17	2/15/17	2/17/17	2/21/17	2/23/17	2/27/17	3/1/17	3/2/17	3/3/17	3/3/17	3/3/17	3/15/17	3/13/17
Actual																								
Apr-17	12/19/16	1/11/16	1/18/17	1/23/17	2/7/17	2/10/17	2/17/17	2/22/17	3/7/17	3/8/17	3/16/17	3/17/17	3/20/17	3/22/17	3/24/17	3/28/17	3/30/17	4/3/17	4/4/17	4/5/17	4/5/17	4/5/17	4/17/17	4/13/17
Actual																								
May-17	1/27/17	2/10/17	2/17/17	2/21/17	3/7/17	3/10/17	3/17/17	3/22/17	4/4/17	4/5/17	4/13/17	4/14/17	4/17/17	4/18/17	4/20/17	4/24/17	4/26/17	4/28/17	5/1/17	5/1/17	5/1/17	5/1/17	5/15/17	5/10/17
Actual																								
Jun-17	2/27/17	3/9/17	3/15/17	3/17/17	4/5/17	4/10/17	4/14/17	4/19/17	5/2/17	5/3/17	5/11/17	5/12/17	5/15/17	5/16/17	5/18/17	5/22/17	5/24/17	5/26/17	5/30/17	5/30/17	5/30/17	5/30/17	6/15/17	6/8/17
Actual																								
Jul-17	3/17/17	4/3/17	4/10/17	4/12/17	4/25/17	4/28/17	5/5/17	5/9/17	5/22/17	5/23/17	6/1/17	6/2/17	6/5/17	6/9/17	6/13/17	6/15/17	6/19/17	6/21/17	6/22/17	6/23/17	6/23/17	6/23/17	7/17/17	7/17/17
Actual																								
Aug-17	4/14/17	5/1/17	5/8/17	5/11/17	5/25/17	5/30/17	6/6/17	6/9/17	6/23/17	6/26/17	7/6/17	7/7/17	7/11/17	7/14/17	7/18/17	7/20/17	7/24/17	7/26/17	7/27/17	7/28/17	7/28/17	7/28/17	8/15/17	8/15/17
Actual																								
Sep-17	4/26/17	5/9/17	5/16/17	5/19/17	6/2/17	6/7/17	6/14/17	6/19/17	8/1/17	8/2/17	8/10/17	8/11/17	8/15/17	8/18/17	8/22/17	8/24/17	8/28/17	8/30/17	8/31/17	9/1/17	9/1/17	9/1/17	9/15/17	9/15/17
Actual																								
Oct-17	6/23/17	7/10/17	7/17/17	7/20/17	8/2/17	8/8/17	8/15/17	8/18/17	9/5/17	9/6/17	9/14/17	9/15/17	9/18/17	9/20/17	9/22/17	9/26/17	9/28/17	10/2/17	10/3/17	10/4/17	10/4/17	10/4/17	10/16/17	10/16/17
Actual																								
Nov-17	7/21/17	8/4/17	8/11/17	8/15/17	8/29/17	9/1/17	9/8/17	9/13/17	9/26/17	9/27/17	10/5/17	10/6/17	10/11/17	10/13/17	10/17/17	10/19/17	10/23/17	10/25/17	10/26/17	10/27/17	10/27/17	10/27/17	11/15/17	11/15/17
Actual																								
Dec-17	8/23/17	9/6/17	9/13/17	9/15/17	9/29/17	10/4/17	10/11/17	10/17/17	10/30/17	######	11/8/17	11/9/17	11/14/17	11/16/17	11/20/17	11/22/17	11/27/17	11/29/17	11/30/17	12/1/17	12/1/17	12/1/17	12/15/17	12/15/17
Actual																								
Jan-18	9/22/17	10/6/17	10/16/17	#####	11/1/17	11/7/17	11/14/17	11/17/17	12/5/17	12/6/17	12/14/17	12/15/17	12/18/17	12/20/17	12/22/17	12/27/17	12/29/17	1/2/18	1/2/18	1/3/18	1/3/18	1/3/17	1/16/18	1/16/18
Actual																								
Bull #1	3/10/17	3/24/17	3/31/17	4/4/17	4/18/17	4/21/17	4/28/17	5/3/17	5/16/17	5/17/17	5/25/17	5/26/17	5/30/17	5/30/17	6/1/17	6/5/17	6/7/17	6/9/17	6/12/17	6/13/17	6/13/17	6/13/17	7/14/17	7/14/17
Actual																								
Bull#2	8/21/17	9/6/17	9/13/17	9/18/17	10/2/17	10/5/17	10/12/17	10/17/17	10/30/17	######	11/8/17	11/9/17	11/14/17	11/16/17	11/20/17	11/22/17	11/27/17	11/29/17	11/30/17	12/1/17	12/1/17	12/1/17	12/15/17	12/15/17
Actual																								

*Partial (ie, If not all of the articles were received on a given date, the cell will give the date that the last article was rec'd.)

AMA AMERICAN MEDICAL ASSOCIATION

AAPC HEALTHCON

CPT-A Process

What happens if issues can not be resolved in scheduled timeframe?

- Referred to *CPT-A* Editorial Board Meetings (meeting 3x/year held in conjunction with the CPT Editorial Panel):
  - Decision made by *CPT-A* EB, eg:
    - Pull article
    - Publish consensus opinion
    - Send article/FAQ back to specialty societies for further revisions/clarifications to the decision made by EB
  - Referred to the CPT Editorial Panel EC
    - Suggest CPT coding solution (to be prepared by specialty society or AMA staff)

CPT-A Process

HOW AN ARTICLE MAY LEAD TO A NEW CODE

- On occasion, during CPT Editorial Board discussion, an issue arises which demonstrates changes in applicability of a code, new procedures being submitted with that code, or lack of clarity that should be addressed with more than just an educational article
- These issues are referred to the Executive Committee and then to the Panel
- If the issue can be clarified without modifications to the code structure, an article is then written which incorporates that clarification
- If the issue appears to merit a new coding solution, the relevant specialty societies are directed to submit a code change application to resolve the issue

CPT-A Exemplars

The case of “epidermal nerve fiber density testing”

- Prior to 2007 the use of code 88356 per CMS claims data was around 1000/per year.
- 88356 (Morphometric analysis; nerve) is a long established CPT created to codify the procedure of peripheral nerve analysis, typically done by neuropathologists in the assessment of peripheral neuropathies, including sensory neuropathies.
    - The service captured in 88356 involves the morphometric measurement of various parameters (eg, total number, density, and diameter of myelinated fibers including myelin thickness and *g* ratio) on epoxy resin-embedded, gluteraldehyde fixed, and toluidine blue stained nerve tissue, typically from the sural nerve.
- A dramatic rise in the volume of (~15x) was noted in subsequent years and was identified in a RUC “High Growth Services” screen.

CPT-A Exemplar #1

The case of “epidermal nerve fiber density testing”

- As a part of the RUC review the predominant specialty (CAP) using 88356 was requested to respond to the utilization screen).

- Investigating the cause identified a new service, performed in high numbers by a limited number of providers.

  - Epidermal nerve fiber density testing (a.k.a., intraepidermal nerve fiber [IENF] density) was identified as a procedure that was rapidly growing in volume that providers were capturing for payment using the 88356 code.

  - This testing requires special histologic evaluation of skin biopsies utilizing quantitative immunohistochemistry for neural elements (ie, panaxonal marker, anti–protein gene product 9.5). The number of intra-epidermal nerve fibers per linear millimeter of epidermis identified by the physician and are reported.

CPT-A Exemplar #1

The case of “epidermal nerve fiber density testing”

- This testing result has been reportedly used in the assessment of sensory neuropathies seen in diabetes mellitus, cancer chemotherapy, as well as idiopathic neuropathies.
- The analysis was quite different from the sural nerve biopsy assessment
- The CAP responded to the RUC with their findings.
  - They were requested to resurvey the 88356 service for potential revaluation
  - They were also requested to write a CPT Assistant article to address their findings regarding IEFN.

CPT-A Exemplar #1

The case of “epidermal nerve fiber density testing”

In the June 2014 Edition of *CPT Assistant* an FAQ was published:

Pathology and Laboratory: Surgical Pathology

Question:
What is the appropriate CPT code to capture epidermal nerve fiber density testing on skin biopsies?

ance. These new codes (as well as the add-on codes 19082, 19084, and 19086) include all of the imaging performed on the guidance modality for that entire procedure (eg, all stereotactic imaging for stereotactic-guided biopsy, all ultrasound imaging for ultrasound-guided biopsy, and all MRI imaging for MRI-guided biopsy).

Note that this new family of codes does not include a mammogram obtained on mammography equipment.

The 2014 National Correct Coding Initiative (NCCI) instructions support this coding recommendation with the following statement: If a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with mammographic guidance (eg, 19281, 19282), the physician should not separately report a post-procedure mammography code (eg, 77051, 77052, 77055-77057, G0202-G0206) for the same patient-encounter. The radiologic guidance codes include all imaging by the defined modality required to perform the procedure.

Pathology and Laboratory: Surgical Pathology

Question: *What is the appropriate CPT code to capture epidermal nerve fiber density testing on skin biopsies?*

Answer: Epidermal nerve fiber density testing (also referred to as intraepidermal nerve fiber [IENF] density) involves special histologic evaluation of skin biopsies utilizing quantitative immunohistochemistry for neural elements (ie, panaxonal marker, anti-protein gene product 9.5). The physician identifies and reports the number of intraepidermal nerve fibers per linear millimeter of epidermis. This report is used in the assessment of sensory neuropathies seen in diabetes mellitus and cancer chemotherapy, as well as idiopathic causes.

There is currently no specific CPT code to encompass IENF-density testing. As no specific CPT code exists for IENF density testing, code 88399, *Unlisted surgical pathology procedure*, should be used to report this service. When reporting an unlisted code to describe a procedure or service, it is 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, and the time, effort and equipment necessary to provide the service.

Although IENF density testing involves quantitative immunohistochemistry, neither CPT code 88342 , *Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide*, nor 88360, *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual*, nor 88361, *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology*, is the appropriate code to report for this service. CPT code 88342 cannot be used because it does not include quantitative immunohistochemistry. CPT codes 88360 and 88361 are not appropriate because the tissue used in IENF is not tumorous, but rather represents grossly normal (typically distal leg) skin.

Similarly, CPT code 88356, *Morphometric analysis; nerve*, is not the appropriate code to use for IENF-density testing either. Nerve morphometry is used in the assessment of peripheral neuropathies, including sensory neuropathies. The service described by code 88356 involves the morphometric measurement of various parameters (eg, number, density, and diameter of myelinated fibers including myelin thickness and g-ratio) on epoxy resin–embedded, glutaraldehyde fixed, and toluidine blue–stained nerve tissue, typically utilizing the sural nerve.

Medicine: Noninvasive Vascular Diagnostic Studies

Question: *May code 93975,* Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study, *and code 93979,* Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study, *be reported together at the same session, or are the components of code 93979 included when code 93975 is reported?*

Answer: Codes 93975 and 93979 may not be reported together on the same day of service when performed by the same physician. The elements of code 93979 are included in code 93975, as indicated by the code descriptor for code 93975, which describes duplex evaluation of arterial supply and venous drainage of an organ(s) in the abdomen, retroperitoneum, or pelvis, while code 93979 describes limited evaluation of the aorta, inferior vena cava, iliac vasculature, or grafts involving these vessels.

Category III

Question: *What is the appropriate code to report a nuclear medicine myocardial sympathetic innervation imaging study?*

Answer: Category III codes 0331T and 0332T were established in 2013 for reporting myocardial sympathetic innervation imaging. Code 0331T describes a planar study, whereas code 0332T describes a planar and single photon emission computed tomography (SPECT) study. The quantitative assessment of the heart to mediastinum (H/M) ratio is included in codes 0331T and 0332T and is not reported separately. ◆

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CPT® Assistant June 2014 / Volume 24 Issue 6

AAPC HEALTHCON

CPT-A Exemplar #1

The case of “epidermal nerve fiber density testing”

In the June 2014 Edition of *CPT Assistant* FAQ:

“There is currently no specific CPT code to encompass IENF density testing “

“…88356 (Morphometric analysis; nerve) is not appropriately used for IENF density testing. “

“As no specific CPT code exists for IENF density testing, 88399 (Unlisted surgical pathology procedure) should be used to codify this service.”

How to find CPT Assistant Materials

- CPT Manual
- CPT Mobile App
- CPT Assistant Annual Index
- CPT Assistant online
- Outside resources (eg, OPTUM360°)

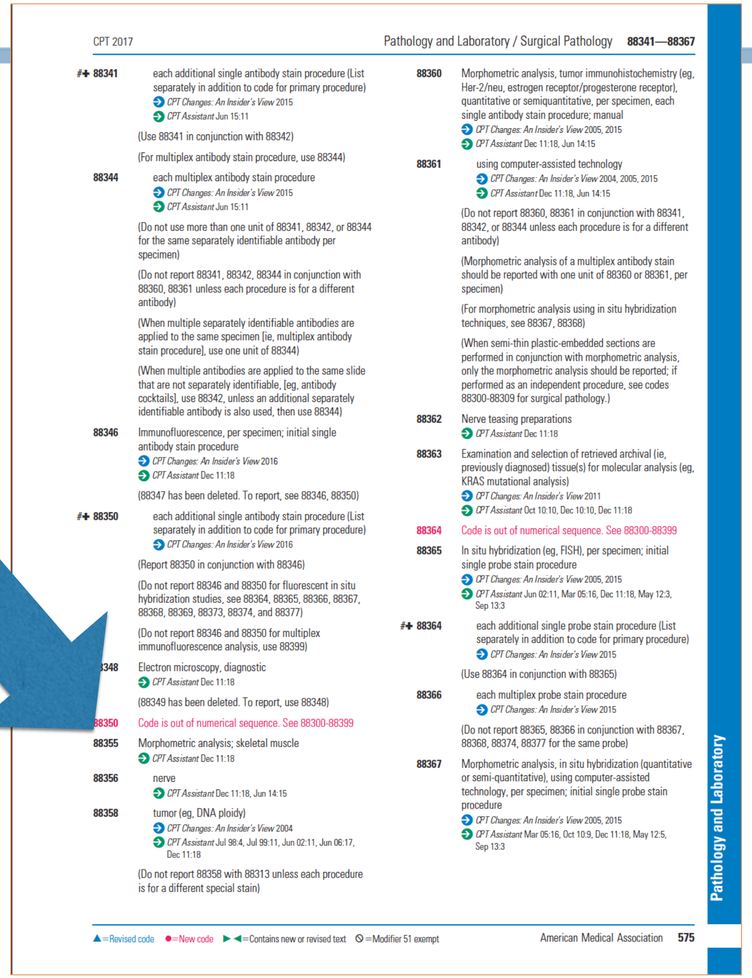
CPT-A Exemplar #1

The case of “epidermal nerve fiber density testing”

88355 Morphometric analysis; skeletal muscle
- *CPT Assistant* Dec 11:18

88356 nerve
- *CPT Assistant* Dec 11:18, Jun 14:15

88358 tumor (eg, DNA ploidy)
- *CPT Changes: An Insider's View* 2004
- *CPT Assistant* Jul 98:4, Jul 99:11, Jun 02:11, Jun 06:17, Dec 11:18



CPT 2017 Pathology and Laboratory / Surgical Pathology **88341—88367**

#✚ **88341** each additional single antibody stain procedure (List separately in addition to code for primary procedure)
- *CPT Changes: An Insider's View* 2015
- *CPT Assistant* Jun 15:11

(Use 88341 in conjunction with 88342)

(For multiplex antibody stain procedure, use 88344)

88344 each multiplex antibody stain procedure
- *CPT Changes: An Insider's View* 2015
- *CPT Assistant* Jun 15:11

(Do not use more than one unit of 88341, 88342, or 88344 for the same separately identifiable antibody per specimen)

(Do not report 88341, 88342, 88344 in conjunction with 88360, 88361 unless each procedure is for a different antibody)

(When multiple separately identifiable antibodies are applied to the same specimen [ie, multiplex antibody stain procedure], use one unit of 88344)

(When multiple antibodies are applied to the same slide that are not separately identifiable, [eg, antibody cocktails], use 88342, unless an additional separately identifiable antibody is also used, then use 88344)

88346 Immunofluorescence, per specimen; initial single antibody stain procedure
- *CPT Changes: An Insider's View* 2016
- *CPT Assistant* Dec 11:18

(88347 has been deleted. To report, see 88346, 88350)

#✚ **88350** each additional single antibody stain procedure (List separately in addition to code for primary procedure)
- *CPT Changes: An Insider's View* 2016

(Report 88350 in conjunction with 88346)

(Do not report 88346 and 88350 for fluorescent in situ hybridization studies, see 88364, 88365, 88366, 88367, 88368, 88369, 88373, 88374, and 88377)

(Do not report 88346 and 88350 for multiplex immunofluorescence analysis, use 88399)

88348 Electron microscopy, diagnostic
- *CPT Assistant* Dec 11:18

(88349 has been deleted. To report, use 88348)

88350 Code is out of numerical sequence. See 88300-88399

88355 Morphometric analysis; skeletal muscle
- *CPT Assistant* Dec 11:18

88356 nerve
- *CPT Assistant* Dec 11:18, Jun 14:15

88358 tumor (eg, DNA ploidy)
- *CPT Changes: An Insider's View* 2004
- *CPT Assistant* Jul 98:4, Jul 99:11, Jun 02:11, Jun 06:17, Dec 11:18

(Do not report 88358 with 88313 unless each procedure is for a different special stain)

88360 Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual
- *CPT Changes: An Insider's View* 2005, 2015
- *CPT Assistant* Dec 11:18, Jun 14:15

88361 using computer-assisted technology
- *CPT Changes: An Insider's View* 2004, 2005, 2015
- *CPT Assistant* Dec 11:18, Jun 14:15

(Do not report 88360, 88361 in conjunction with 88341, 88342, or 88344 unless each procedure is for a different antibody)

(Morphometric analysis of a multiplex antibody stain should be reported with one unit of 88360 or 88361, per specimen)

(For morphometric analysis using in situ hybridization techniques, see 88367, 88368)

(When semi-thin plastic-embedded sections are performed in conjunction with morphometric analysis, only the morphometric analysis should be reported; if performed as an independent procedure, see codes 88300-88309 for surgical pathology.)

88362 Nerve teasing preparations
- *CPT Assistant* Dec 11:18

88363 Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)
- *CPT Changes: An Insider's View* 2011
- *CPT Assistant* Oct 10:10, Dec 10:10, Dec 11:18

88364 Code is out of numerical sequence. See 88300-88399

88365 In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure
- *CPT Changes: An Insider's View* 2005, 2015
- *CPT Assistant* Jun 02:11, Mar 05:16, Dec 11:18, May 12:3, Sep 13:3

#✚ **88364** each additional single probe stain procedure (List separately in addition to code for primary procedure)
- *CPT Changes: An Insider's View* 2015

(Use 88364 in conjunction with 88365)

88366 each multiplex probe stain procedure
- *CPT Changes: An Insider's View* 2015

(Do not report 88365, 88366 in conjunction with 88367, 88368, 88374, 88377 for the same probe)

88367 Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure
- *CPT Changes: An Insider's View* 2005, 2015
- *CPT Assistant* Mar 05:16, Oct 10:9, Dec 11:18, May 12:5, Sep 13:3

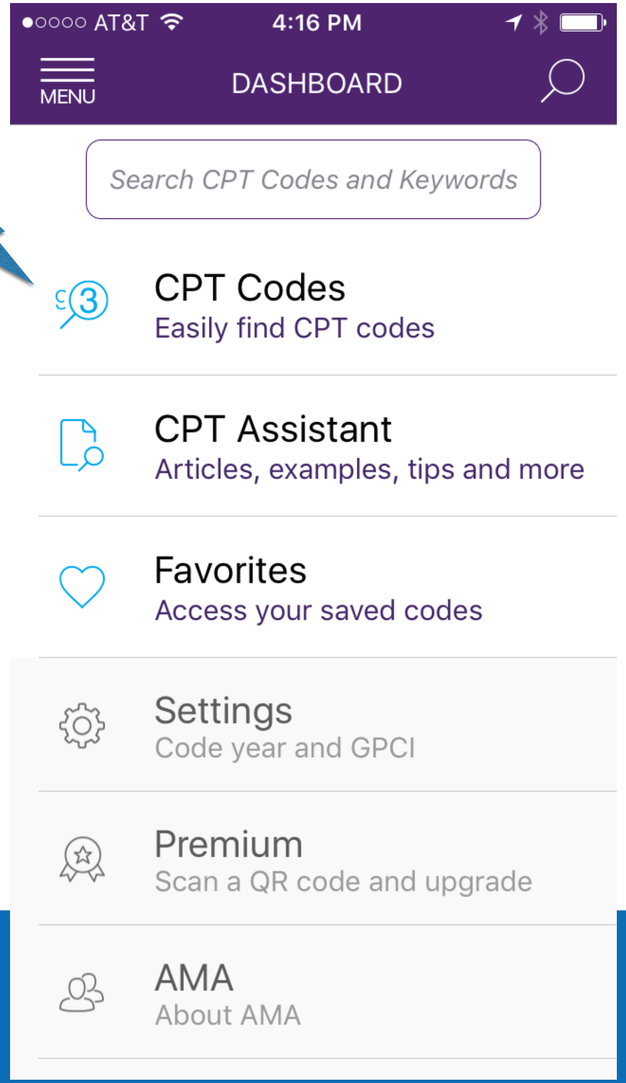
▲=Revised code ●=New code ►◄=Contains new or revised text ⃠=Modifier 51 exempt American Medical Association **575**

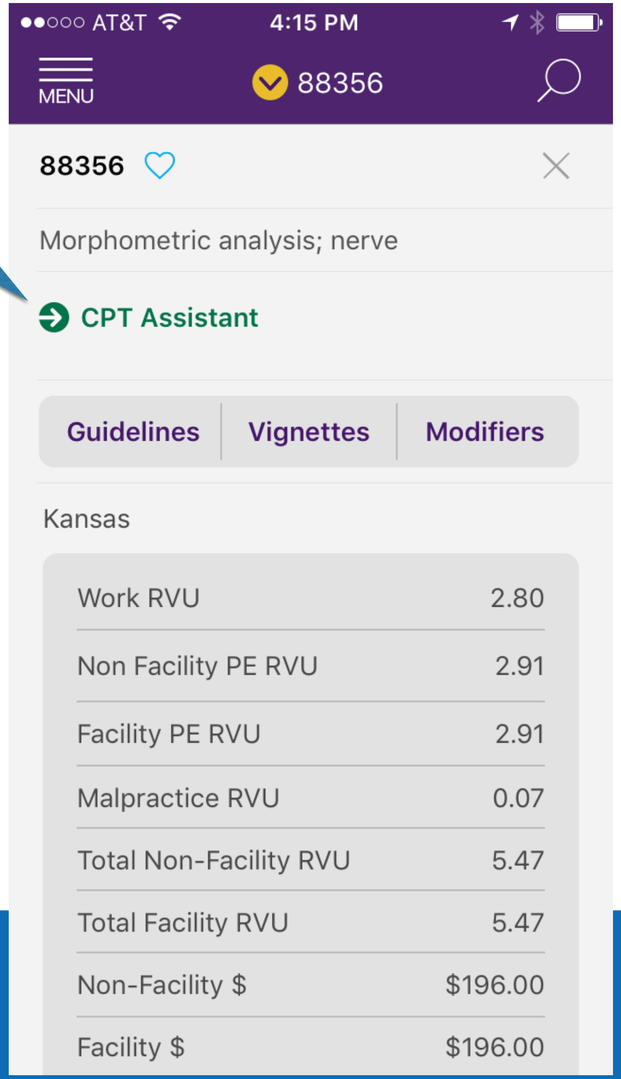
Pathology and Laboratory

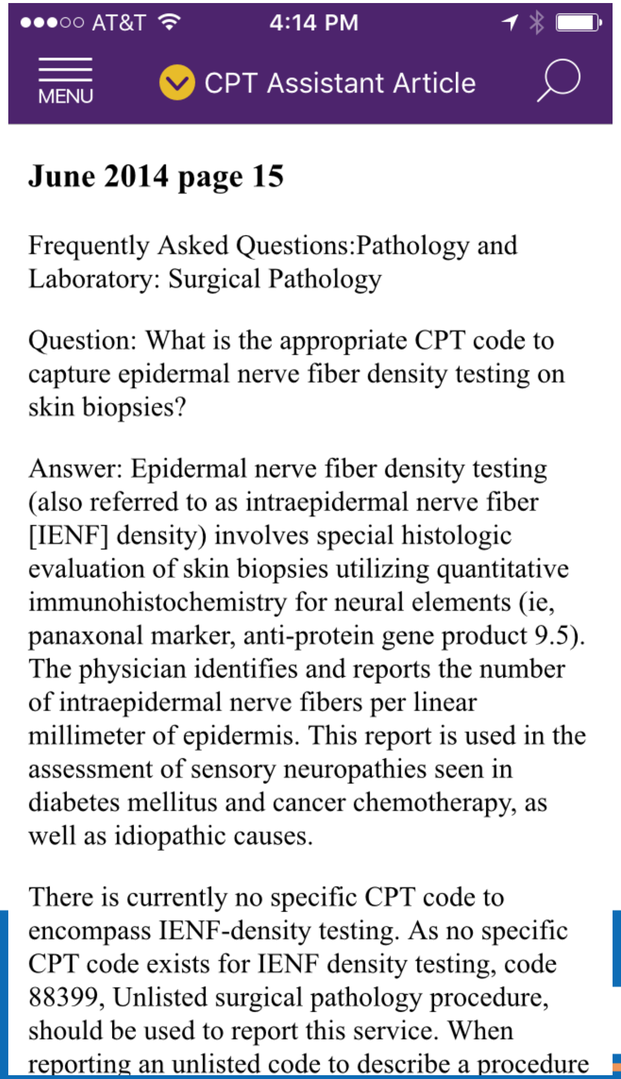
AAPC HEALTHCON

CPT-A Exemplar #1

The case of “epidermal nerve fiber density testing”







CPT-A Exemplar #1

Back Issue Index–Winter 1990-December 2016

The following index provides a list of all *CPT Assistant* articles since winter 1990. Each entry is alphabetized by article title, followed by the issue number, year and month or season, and page number in which the article begins.

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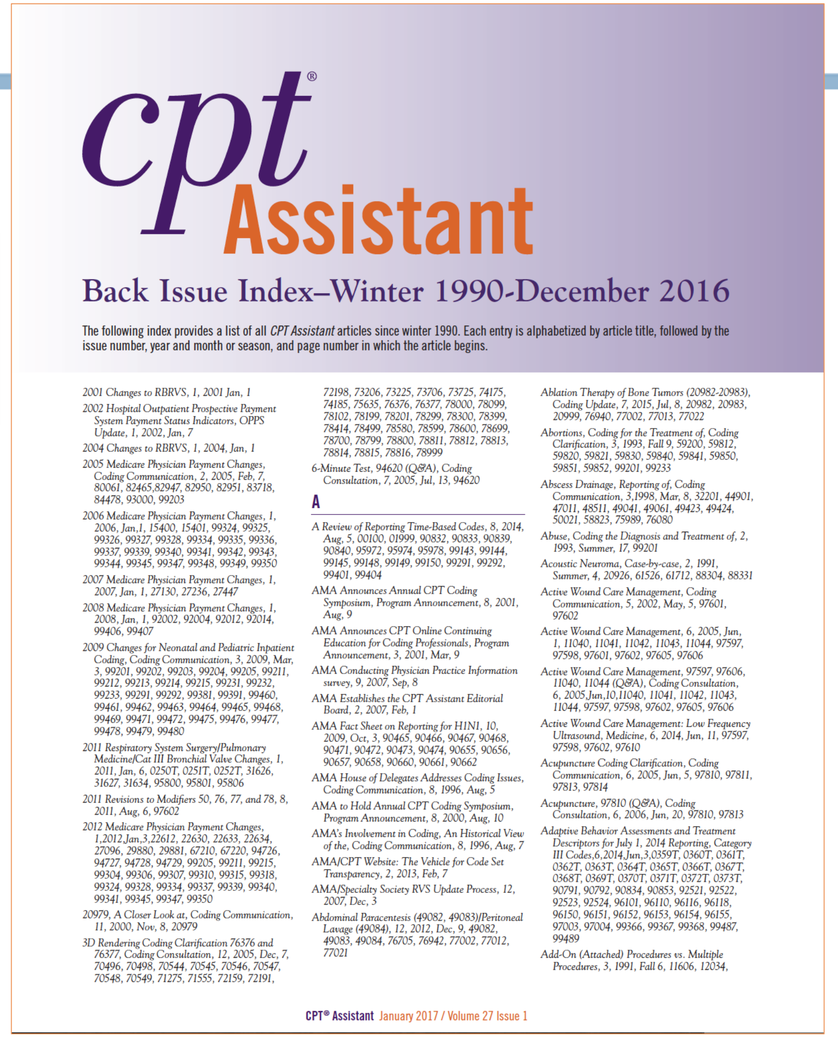

cpt® Assistant

Back Issue Index–Winter 1990-December 2016

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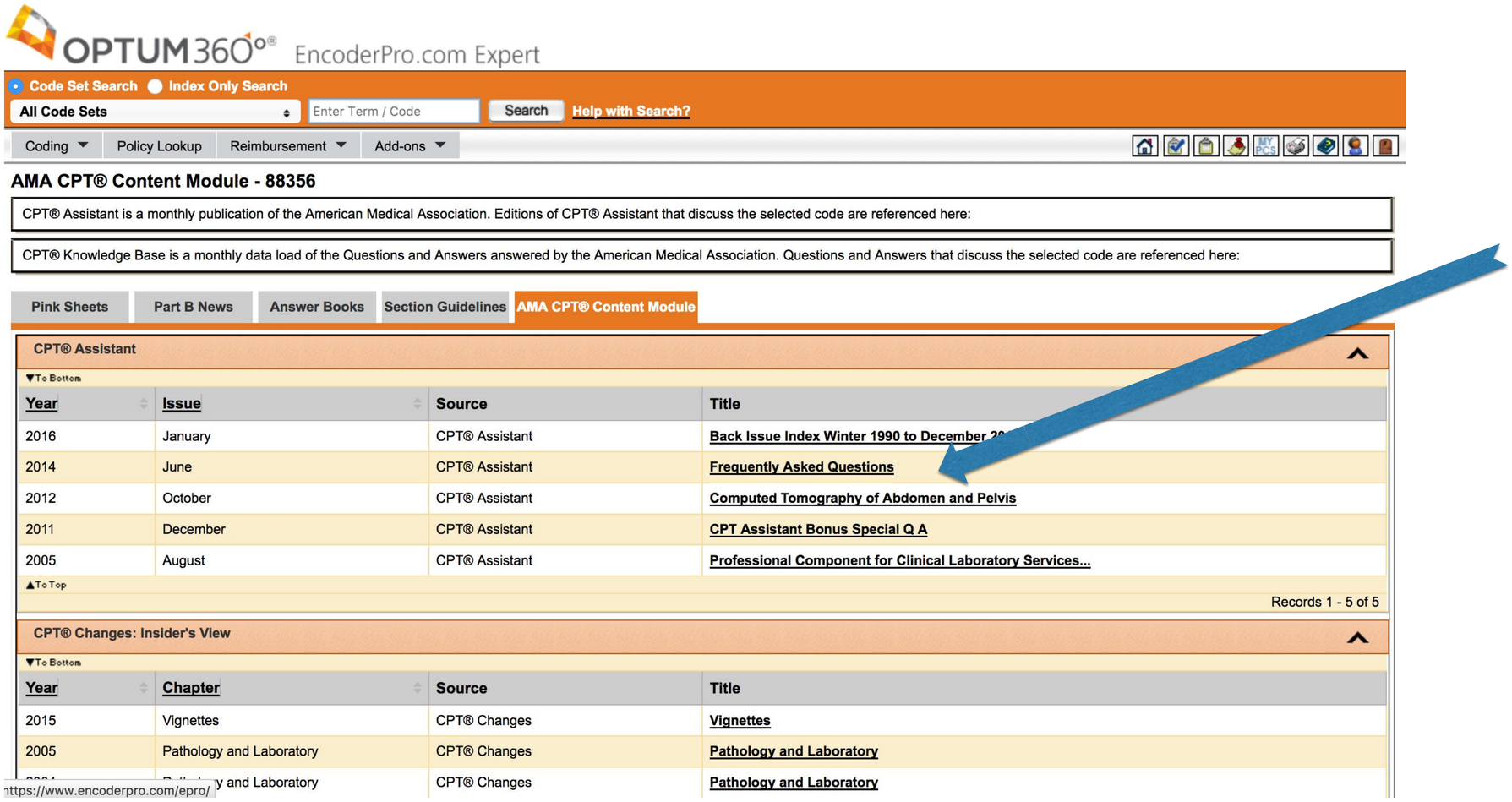
AAPC HEALTHCON

CPT-A Exemplar #1

The case of “epidermal nerve fiber density testing”

CPT-A Exemplar #1



CPT-A Exemplar #1

The case of “epidermal nerve fiber density testing”

- Result:
  - 21% decrease in the volume of 88356 from 2013 to 2015!

CPT-A Exemplar #2

The case of “Neurostimulator electronic analysis ”

- 2013 RUC-RAW identified 95971 and 95972 as high volume growth services & requested that these services be surveyed.

- During the 2014 RUC survey review they recommended that codes 95971, 95972 and 95973 be referred to CPT to address the entire family regarding the time referenced in the CPT code descriptors. Specifically noting that code 95972 specifies “first hour” but survey results indicated the majority of physicians reporting this code take less than 30 minutes to complete the service.

- A coding proposal was prepared by specialty societies, to address this concern.

http://www.medtronic.com/us-en/patients/treatments-therapies/drug-pump-chronic-pain/getting-a-device/neurostimulators-surgery.html

CPT-A Exemplar #2

The case of “Neurostimulator electronic analysis ”

- The CPT Editorial Panel approved for 2016:
  - Modification of 95972, to strike reference to time
  - Deletion of 95973, that previously referred to “each additional 30 minutes after first hour”

- It was determined that this modification to CPT*2016* was significant enough to warrant additional notification and explanation in CPT Assistant, as it appeared that there was a potential for inappropriate use of these codes.

CPT-A Exemplar #2

The case of “Neurostimulator electronic analysis ”

Coding Update: Neurostimulators, Analysis-Programming

The Neurostimulators, Analysis-Programming subsection guidelines, which is related to criteria used to report simple or complex programming of neurostimulators, were revised in the Current Procedural Terminology (CPT®) 2016 code set. The revised guidelines clearly describe the intent of each code in this subsection and differentiate between “simple” vs “complex” programming procedures (ie, identifying three or fewer parameters for simple vs four or more for complex procedures). This coding update provides an overview of the 2016 changes.

95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

95971 simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

▲95972 complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

95974 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour

+95975 complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

(Use 95975 in conjunction with 95974)

95978 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour

+95979 each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

(Use 95979 in conjunction with 95978)

95980 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming

95981 subsequent, without reprogramming

95982 subsequent, with reprogramming

Simple intraoperative or subsequent programming of the neurostimulator pulse generator/transmitter (95971) includes changes to three or fewer of the following parameters: rate; pulse amplitude; pulse duration; pulse frequency; eight or more electrode contacts; cycling; stimulation train duration; train spacing; number of programs; number of channels; alternating electrode polarities; dose time (stimulation parameters changing in time periods of minutes, including dose-lockout times); and more than one clinical feature (eg, rigidity, dyskinesia, tremor). On the other hand, complex intraoperative or subsequent programming (95972, 95974, 95975, 95978, and 95979) includes changes to more than three of the above. Codes 95974 and 95978, which are reported for the first hour of electronic analysis, requires the use of modifier 52 for analysis that is less than 31 minutes in duration.

In addition, code 95973 was identified by the American Medical Association/Specialty Society Relative Value

continued on page 11

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CPT-A Additional Exemplars

"The names have be changed to protect the innocent "
(The articles that you will **NOT** see in *CPT Assistant*)

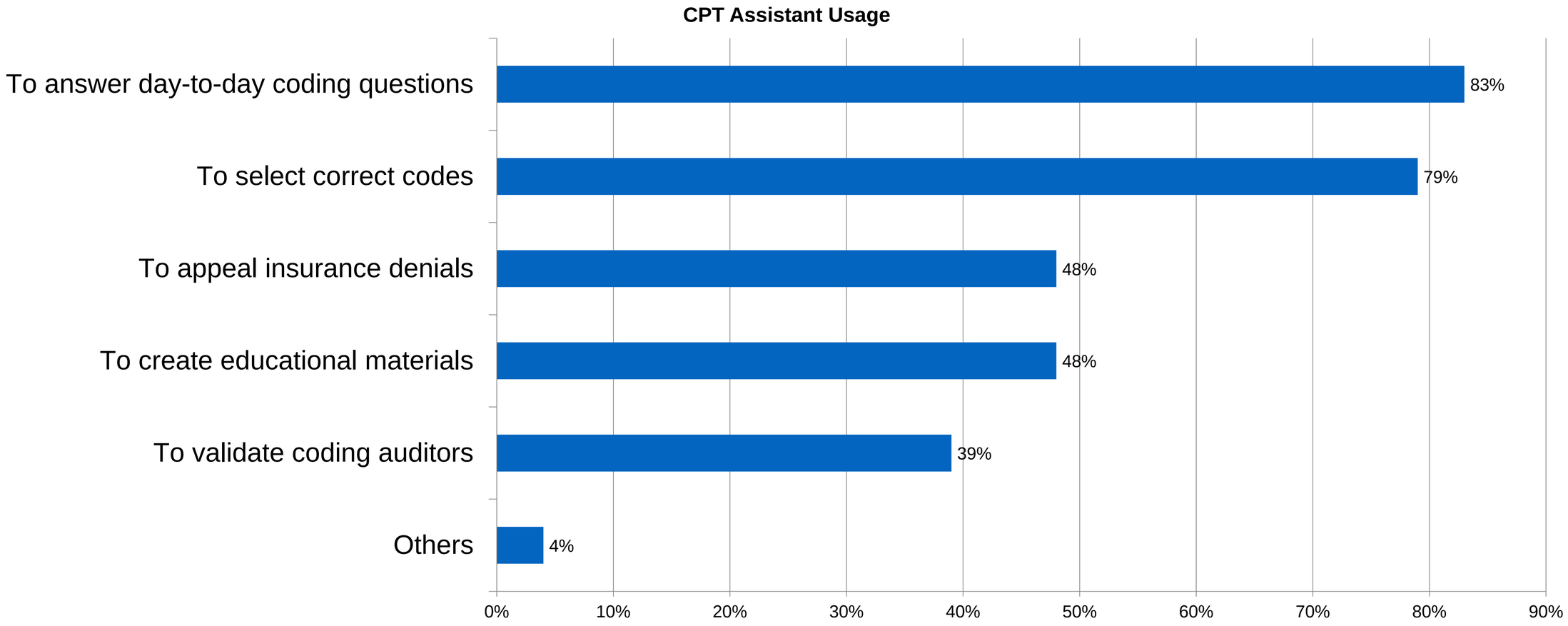
1. Specialty society prepares an article to hallmark a new use for an established code series for a new service (a.k.a. code re-birth!)
2. Specialty society prepares an article to provide rebuttal to a payor policy determination.
3. Payor Medical Director suggests article to legitimize payor policy determination.

CPT-A Additional Exemplars

"The names have be changed to protect the innocent "
(The articles that you will not see in *CPT Assistant*)

The role of CPT Assistant is never to redefine the use of CPT, rather to clarify the appropriate use of the codeset.

What you say is the primarily use of CPT Assistant*



*Online survey of current subscribers 3/15

How is *CPT-A* used nationally?

- CMS and Contractor Medical Directors (CMDs) use CPT Assistant content as guidance to set NCD and LCD policies
- Many third party payers (eg, Blue Cross Blue Shield) use the content as the "**official source**" when reviewing claims data, as well as setting payer policies
- The Relativity Assessment Group (RAW) of the RUC use the content when determining proper utilization of codes
- AHA and other organizations use the content as the official source on setting outpatient hospital coding compliance programs
- Specialty societies and State medical societies use the information to educate their members and other users on proper use of the CPT code set

CPT Assistant (*CPT-A*) Principles

Perspectives of the current Editorial Board Chair

- CPT-A is an excellent source to provide authoritative guidance to assist in the appropriate and consistent use of the CPT code set
- The CPT coding manual must be written in enough detail and specificity to make *CPT-A* an ancillary resource in the vast majority of coding areas. (prospective and retrospective of code creation)
- *CPT-A,* like the coding manual should be self-explanatory for the majority of the readership.

CPT Assistant in a nutshell!

- *CPT-A* imparts coding advice from an AMA perspective as the official source
- *CPT-A* provides a vehicle for reducing conflict between providers, third-party payers, and specialty societies
- *CPT-A* provides support to CPT Panel, Editorial Board, & RUC (RAW) process
- Other organizations produce coding reference content, but none have ability to replicate the authority of *CPT-A*!