

Anesthesia CPT Code Changes for 2015

The American Medical Association recently published new, deleted and revised CPT® codes for use in 2015 coding and billing. Here are the anesthesia and pain management changes for 2015.

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Anesthesia Codes

New Codes

TAP Blocks

Transversus abdominis plane (TAP) blocks that are administered for post-operative pain control will have specifically identified codes for claims submission.

In the past pain management and anesthesia providers utilized general injection or infusion codes for these services; however, the RUC committee (AMA/Specialty Relative Value Scale Update Committee) has created (4) new CPT ® codes which appear on the Medicare Physician Fee schedule beginning January 1, 2015.

The codes are categorized by injection and infusion and are differentiated with unilateral and bilateral procedures.

64486 - Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

64487 - Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)

64488 - Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)

64489 - Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)

TEE (Transesophageal Echocardiography)

TEE is often used by anesthesiologists for services included in the monitoring of cardiac procedures. A new, more comprehensive code for TEE monitoring was created for 2015.

93355, Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (e.g., TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri-and intra-procedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D.

Note: TEE monitoring is not reimbursable per Medicare

Deleted CPT Codes

00452 Anesthesia for procedures on clavicle and scapula; radical surgery

(Removal of this service occurred as a result of a code set review and determination that this service was underutilized, or the reporting of the code has such a low frequency of use, less than ten times per year, that it was no longer necessary.)

00622 Anesthesia for procedures on thoracic spine and cord; thoracolumbar sympathectomy

(Removal of this service occurred as a result of a code set review and determination that this service was underutilized, or the reporting of the code has such a low frequency of use, less than ten times per year, that it was no longer necessary.)

00634 Anesthesia for procedures in lumbar region; chemonucleolysis

(Removal of this service occurred as a result of a code set review and determination that this service was underutilized, or the reporting of the code has such a low frequency of use, less than ten times per year, that it was no longer necessary.)

Revised Anesthesia CPT Codes

There were no revised anesthesia codes for 2015

CPT Changes for Pain Management

Arthrocentesis/Joint Injection/Aspiration Codes

CPT has created a new set of codes for joint aspiration and/or injection which include ultrasound guidance (20604, 20606, 20611). Additionally, existing codes (20600, 20605, and 20610) were revised to indicate when an Arthrocentesis, joint injection or aspiration is performed *without* ultrasound guidance.

New Codes

20604 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting (Do not report 20600, 20604 in conjunction with 76942) (If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, 77021)

20606 ;with ultrasound guidance, with permanent recording and reporting (Do not report 20605, 20606 in conjunction with 76942) (If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, 77021)

20611 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

Revised Codes

20600 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); ~~small joint or bursa (eg, fingers, toes)~~without ultrasound guidance

20605 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); ~~intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)~~without ultrasound guidance

20610 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); ~~major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)~~without ultrasound guidance

Vertebroplasty

New Codes

22510 Percutaneous Vertebroplasty (bone biopsy included when performed) 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511 ;lumbosacral

22512 ; each additional cervicothoracic or lumbosacral, vertebral body (List separately in addition to code for primary procedure) (Use 22512 in conjunction with 22510, 22511)

(Do not report 22510, 22511, 22512 in conjunction with 20225, 22310, 22325, 22327 when performed at the same level as 22510, 22511, 22512)

(Do not report 22510, 22511, 22512 in conjunction with 20225, 22310, 22325, 22327 when performed at the same level as 22510, 22511, 22512)

22513 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included with performed) using mechanical device (eg, kyphoplasty) 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance

22514 ;lumbar

22515 ;each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure) (Use 22515 in conjunction with 22513, 22514) (Do not report 22513, 22514, 22515 in conjunction with 20225, 22310, 22315, 22325, 22327 when performed at the same level as 22513, 22514, 22515)

Ultrasound Guidance For Needle Placement

Changes were made to the parenthetical comments to differentiate the codes that 76942 cannot be billed with given that many codes now contain the ultrasound guidance within the new 2015 CPT code set.

76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, location device,), imaging supervision and interpretation (Do not report 76942 in conjunction with 10030, 19083, 19285, 20604, 20606, 20611, 27096, 322554, 32555, 32556, 32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 64479-64484, 64490-64495, 76972, 2013T- 0218T, 0228T-0231T, 0232T , 0249T, 0301T)

Myelography

The myelography code section has undergone a few changes. New codes have been created to include the supervision and interpretation. Additionally, the existing code for myelogram injection has been revised to specify the lumbar region.

CPT code 62284 has been previously used for injection procedures for myelography and/or computed tomography, lumbar (other than C1-C2 and posterior fossa) to report the injection procedure along with either fluoroscopic guidance (77003) or the appropriate conventional radiological myelogram code plus the appropriate spinal CT code.

CPT has added new codes for 2015 that will change the reporting for myelograms going forward.

CPT® code 62284 along with the radiology codes were changed in the parenthetical notes below 62284, 72240, 72255, 72265, and 72270 has changed for 2015 reporting as follows:

- (Do not report 62284 in conjunction with 62302, 62303, 62304, 62305, 72240, 72255, 72265, 72270)
- (When both 62284 and 72240, 72255, 72265, 72270 are performed by the same physician or other qualified health care professional for myelography, see 62302, 62303, 62304, 62305)

In summary, when a myelogram injection with conventional radiological imaging is performed by the same provider, one of the new codes 62302-62305 should be assigned rather than the injection procedure (62284) and the radiological procedure (72240, 72255, 72265, 72270) separately.

NOTE: The only time these two codes would be used going forward is when one provider performs the injection and a different provider interprets the radiology study.

Below is a list of the new combined codes that have been added that include both the injection procedure and the myelogram and are defined by region of the spine being imaged. The new codes are:

Revised Codes

62284 Injection procedure for myelography and/or computed tomography,

~~spinal~~ lumbar (other than C1-C2 and posterior fossa) (Do not report 62284 in conjunction with 62302,62303,62304, 62305,72240, 72255, 72265, 72270)

New Codes

62302 Myelography via lumbar injection, including radiological supervision and interpretation; cervical

62303 ;thoracic

62304 ;lumbosacral

62305 ;2 or more regions (eg lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)

Other Changes

Parenthetical changes were made to the comment section of 72265 which are now necessary given the new myelography codes that now contain these services.

72265 Myelography, lumbosacral, radiological supervision and interpretation(72265 in conjunction with 62284, 62302, 62303, 62304,. 62305) (When both 62284 and 72265 are performed by the same physician or other qualified health care professional for lumbosacral myelography, use 62304) (For complete lumbosacral myelography via injection procedure at C1-C2, see 61055, 72265)

Post Op Pain Blocks

TAP Blocks

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Drug Screening

Presumptive Drug Class Screening

80300 Drug screen, any number of drug classes from Drug Class List A, any number of non-TLC devices or procedures (eg, immunoassay) capable of being read by direct optical observation, including instrumented-assisted with performed (eg, dipsticks, cups, cards ,cartridges) per date of service

80301 single drug class method, by instrumented test systems, (eg, discrete multichannel chemistry analyzers utilizing immunoassay or enzyme assay), per date of service

80302 Drug screen presumptive, single drug class from Drug Class List B, by immunoassay (eg, ELSIA) or non-TLC chromatography without mass spectrometry (eg, GC, HPLC), each procedure

80303 Drug screen, any number of drug classes persumptive, single or multiple drug class method; thin layer chromatography procedure(s) (TLC) (eg, acid, neutral alkaloid plate)per date of service

80304 not otherwise specified presumptive procedures (eg, TOF, MALDI, LDTD, DESI, DART) each procedure

Definitive Drug Testing

(Use 80320-80377 to report definitive drug class procedures. Definitive testing may be qualitative, quantitative, or a combination of qualitative and quantitative for the same patient on the same date of service)

82541 Column chromatography/mass spectrometry (eg GC/MS or HPLC/MS) non-drug analyte not elsewhere specified qualitative single stationary and mobile phase

82542 Column chromatography/mass spectrometry (eg GC/MS or HPLC/MS) non-drug analyte; not elsewhere specified; quantitative, single stationary and mobile phase

82543 Column chromatography/mass spectrometry (eg GC/MS or HPLC/MS) non-drug analyte; analyte not elsewhere specified; stable isotope dilution, single analyte, quantitative, single stationary and mobile phase

82544 Column chromatography/mass spectrometry (eg GC/MS or HPLC/MS) non-drug analyte; stable isotope dilution, multiple analytes, quantitative, single stationary and mobile phase

(For column chromatography/mass spectrometry for drugs or substances, see Drug Assay 80300, 80301, 80302, 80303, 80304, 80320-80377 or specific analyzer code(s) in the Chemistry section)