Dear Valued Optum360 Customer:

Thank you for your purchase of the *2018 Coders' Desk Reference for Procedures*. We have discovered a database error that introduced several discrepancies into the 2018 book, mostly in the Category III codes. The issue has been resolved, and the corrections follow in this document. The information will print correctly in subsequent editions of the *Coder's Desk Reference for Procedures*. We sincerely regret any inconvenience this may have caused and are committed to providing you with the most accurate information possible.

Thank you,

Karen Adkins, CPC, CCS-P, Clinical/Technical Editor

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- **Page 180**

  Code range 22902-22903 is incorrect. It should be 22904-22905 for the lay description.

- **Page 255**

  Code range 27690-27692 and its lay description did **not** publish. The correct information is:

  27690-27692

  Because these procedures involve transfer or transplant of a single tendon from a number of different sites on the foot, the exact procedure will differ depending on the specific tendon involved. When transfer of the anterior tibial tendon is performed, an anterior lower-leg incision is made and the tendon extracted and passed posteriorly through the interosseous membrane to the calcaneus. A posterior heel incision is made and the tendon end is fixed to the calcaneus and/or Achilles tendon. The wound is closed in layers over a drain with a subcutaneous layer closed so that the skin can be brought together under minimal tension. The patient is placed into a dressing incorporating plaster splints. Report 27690 for superficial transfer or transplant of a single tendon. Report 27691 for deep transfer or transplant of a single tendon. Report 27692 for each additional tendon.

- **Page 256**

  Code range 27730-27734 and its lay description should **not** have published and should be disregarded.

- **Page 287**

  Code range 30118-30120 is incorrect for the lay description; it should be 30124-30125 and follow 30120. The correct information is:

  30124-30125

  The physician removes a dermoid (developmental) cyst of the nose that may be associated with the soft tissue only in 30124 or may extend into bone and/or cartilage in 30125. If associated with the nasal bone, the usual location is at the bone-cartilage junction. Dependent on the size and location, the cyst may be removed using skin or intranasal incisions. A fistula opening may be present and its tract would be excised. Commonly, an incision is made overlying the cyst in the nasal skin. The cyst is removed from its cavity using curettes. The defect size dictates post-removal cavity packing and/or separately reportable reconstruction. Incisions may be closed in single and layers.

- **Page 288**

  Code range 30130-30140 is incorrect for the lay description. The correct code range is 30150-30160 and should follow 30140:

  30150-30160

  The physician resects a portion of the nose in 30150 or the total nose in 30160, leaving a surgical defect. The extent of the resection is determined by the extent of the tumor or trauma. A full thickness incision is made through the external nose. All diseased or damaged soft tissue is excised to clear margins. Underlying bone or cartilage may be removed. Exposed bone or cartilage is covered with mucosal flaps or separately reportable skin grafts.

- **Page 544**

  Code 58674 and its lay description display incorrectly on this page; it is a resequenced code and should have displayed on page 540 following code 58540.

- **Page 877**

  Code range 0085T-0098T and lay description should **not** have published and should be disregarded.

- **Page 878**

  Code range 0109T-0110T and lay description should **not** have published and should be disregarded.

- **Page 885**

  Code range 0342T-0345T and lay description should **not** have published and should be disregarded.

- **Page 886**

  Code range 0350T-0351T and lay description should **not** have published and should be disregarded.

- **Page 887**

  Code range 0361T-0362T and lay description should **not** have published and should be disregarded.

- **Page 888**

  Code range 0368T-0371T and lay description should **not** have published and should be disregarded.

  Code range 0372T-0374T and lay description should **not** have published and should be disregarded.

- **Page 890**

  Code range 0384T-0386T and lay description should **not** have published and should be disregarded.

- **Page 891**

  Code range 0395T-0396T and lay description should **not** have published and should be disregarded.

  Code range 0396T-0399T and lay description should **not** have published and should be disregarded.

- **Page 892**

  Code range 0397T-0400T and lay description should **not** have published and should be disregarded.

- **Page 893**

  The lay description for code range 0400T-0401T is incorrect; the correct information is:

  0400T-0401T

  A multi-spectral digital skin lesion analysis (MSDSLA) device employs the use of a handheld scanner to shine light, varying from visible (430nm) to almost infrared (950nm) wavelengths, to evaluate suspicious skin lesions with clinical or histological characteristics suggestive of melanoma, up to 2.5 mm beneath the skin. Data gathered from the scanner is analyzed via a data processor to evaluate the lesion's characteristics utilizing proprietary computer algorithms. The lesions are categorized as having a high (positive) or low (negative) degree of morphologic changes. Lesions classified as positive are recommended for biopsy; negative lesions are further evaluated to determine if a biopsy is warranted. This noninvasive technique is designed to assist dermatologists in evaluating skin lesions not visible to the human eye in order to accurately classify lesions, increase detection rates of melanoma, and decrease the number of unnecessary biopsies, and is only intended for use on suspicious pigmented skin lesions by trained dermatologists. Currently, only one computer-based optical imaging device has been approved by the FDA and is referred to as MelaFind®. Report 0400T for an evaluation of one to five lesions and 0401T for six or more lesions.

  Code range 0401T-0403T [0488T] and lay description should **not** have published and should be disregarded.

- **Page 894**

Code range 0405T-0406T is incorrect for the lay description; it should be 0406T-0407T and follow 0405T:

0406T-0407T

The physician performs nasal endoscopy, a procedure that enables the direct vision evaluation of the nasal and sinus passages via a rigid or a flexible fiberoptic endoscope inserted through the nostril to view the ethmoid sinuses. The endoscope offers the physician images of superior quality and clarity, culture and tissue sampling, control of nose bleeding, and the ability to perform surgery with the goal being to enlarge the narrow opening or channel of the sinus and improve drainage. Technology using balloons to widen the sinus opening may also be utilized. A drug eluting stent (DES) is a surgically inserted scaffold that aids in the healing of affected tissue by releasing drug-loads slowly and continuously from polymer matrices to affected areas in the sinuses or nasal cavities for a prolonged period of time. Nasal endoscopy may be performed under local or general anesthesia and, in some cases, in the physician's office. Report 0407T when a biopsy, polypectomy, or debridement is also performed.

Code range 0407T-0408T is incorrect for the lay description; it should be 0408T-0411T and follow 0406T-0407T:

0408T-0411T

Cardiac contractility modulation (CCM) is utilized to improve ventricular pump function and for patients who have normal QRS duration. The device consists of a programmable and rechargeable generator, powered by a lithium battery. The patient is given local anesthesia and the device is implanted within a pocket on the right side of the chest below the collarbone with an electrode fixed on the carotid sinus. One incision allows access to the cervical vagal nerve with another incision made for insertion of the right ventricular electrode. The vagal electrode is connected to the generator via subcutaneous tunnel. This unit includes three standard leads placed transvenously into the right side of the heart: one in the right atrium for sensing and two in the right ventricle for sensing and delivery of impulses. These impulses do not change the cardiac sequence (rhythm), but instead modify contractility by sending high-energy impulses to the myocardium during the refractory period. The unit allows the patient the ability to recharge the battery with an external charger that operates transcutaneously. This is required once a week and typically takes about 90 minutes. Programming and interrogation follows the same process as a pacemaker. Report 0408T for insertion or replacement of the entire system, including evaluation and programming when performed; 0409T for insertion or replacement of the pulse generator only; 0410T for insertion or replacement of the atrial electrode only; and 0411T for insertion or replacement of the ventricular electrode only.

Code range 0412T-0413T and lay description did **not** publish; the correct information is:

0412T-0413T

In 0412T, the physician removes a cardiac contractility modulation (CCM) system. The pocket is opened. The existing system is disconnected from the wire and removed. In 0413T, the electrodes are removed (atrial or ventricular). Previous insertion incisions may be reopened for removal of electrodes, which are disconnected from the generator as well as the vagal nerve, right atrium, and right ventricle.

Code range 0417T-0418T and lay description did **not** publish; the correct information is:

0417T-0418T

A programming device evaluation (0417T) or interrogation (0418T) is performed in person in order to test the device's function and select the most favorable permanent programmed values. Patients with previously implanted cardiac contractility modulation (CCM) systems require periodic programming device evaluations. These diagnostic procedures include a face-to-face assessment of all device functions. Components that must be evaluated in order to assign a code from this range include the battery, leads, capture and sensing function, and programmed parameters. Stored and measured data regarding these components are retrieved using an office, hospital, or emergency room instrument. This information is assessed to discern battery voltage, lead impedance, and settings, as well as to determine the device's current programming. In 0417T, if necessary, the sensing value and rate response, upper and lower heart rates, impulses, and diagnostics are adjusted. These codes include physician or other qualified health care professional analysis, review, interpretation, and report, and are assigned per procedure. They also include connection, recording, and disconnection.

Code range 0419T-0420T and lay description did **not** publish; the correct information is:

0419T-0420T

Neurofibromas are benign soft tissue tumors that develop from the nerve tissue of the peripheral nerve, which are the nerves from the spinal cord that extend into the trunk and extremities. While a patient may present with a single neurofibroma, usually multiple tumors are present. In these cases, the clinician often suspects neurofibromatosis, a genetic condition passed from parent to child. There are two categories of neurofibromatosis: neurofibromatosis type 1 (NF1) and neurofibromatosis type 2 (NF2), which is significantly more severe. Some of the identifying characteristics of NF1 include, but are not limited to, more than one neurofibroma present, learning disabilities, cafe'-au-lait spots, bone deformities, Lisch nodules on the eye, and tumors on the adrenal gland, brain, or spinal cord. These characteristics are also common in type 2, along with a greater likelihood of cataracts and benign ear tumors developing on the vestibulocochlear nerve, often in both ears, which can create balance and hearing problems. Neurofibromas vary in size ranging from a small tumor arising from a skin nerve (cutaneous) to severe enlargement of an extremity, such as in cases of elephantitis arising from a larger nerve. Destruction of neurofibroma is determined by a number of factors, including type, location, and size of the tumor. Destruction of neurofibromas may be performed via straightforward excision using a scalpel, ablation through desiccation, or vaporized via electrosurgery. For patients presenting with a significant amount of neurofibromas, electrodesiccation may be performed. The surgeon utilizes a device to apply an electrical current to the tumor and dries out the tissues the tumor is in contact with. This process allows the surgeon to go into deeper tissue than is possible with other methods. In cases of severe neurofibromatosis, excision and electrodesiccation may be performed in conjunction with each other. For more superficial tumors, fulguration and electrocautery techniques may be used. Another method of destruction may include stereotactic radiosurgery, a minimally invasive technique that destroys the tumors using highly focused beams of radiation resulting in minimal damage to the healthy tissue surrounding the tumor, as well as less side effects than the patient might experience with more traditional surgery. Report 0419T for destruction of 50 or more neurofibromas of the face, head, and neck and 0420T for destruction of 100 or more neurofibromas on the trunk or extremities.

Code range 0420T-0421T and lay description should **not** have published and should be disregarded.

- **Page 895**

Code range 0422T-0424T and lay description should **not** have published and should be disregarded.

Code range 0424T-0427T and lay description did **not** publish; the correct information is:

0424T-0427T

The neurostimulator system for treatment of central sleep apnea consists of a pulse generator much like a pacemaker, a stimulation electrode, a sensing electrode, and, in some models, an external programmer unit. Respiration sensing is accomplished by the electrodes determining the patient's position at rest/activity to allow for programming of applicable delivery times. This unit assists stable breathing by preventing episodes of apnea followed by rapid breathing. Patients assessed for this therapy have obstructive sleep apnea not resolved or tolerated by CPAP treatment, with a BMI of 32kb/m2 or less, and have no other implantable devices (i.e., pacemaker). The electrode is inserted through the axillary or subclavian vein and placed in the left pericardiophrenic vein or the right brachiocephalic vein. The sensing electrode is inserted into the azygos vein (on the back of the thorax, which flows into the SVC). The generator is inserted into a pocket in the pectoral region, much like a pacemaker. The electrodes are connected to the generator and tested prior to pocket closure. Report 0424T for insertion or replacement of the entire system; 0425T for insertion or replacement of the sensing lead only; 0426T for insertion or replacement of the stimulation lead only; and 0427T for insertion or replacement of the pulse generator only.

Code range 0428T-0430T and lay description did **not** publish; the correct information is:

0428T-0430T

The neurostimulator system for treatment of central sleep apnea consists of a pulse generator much like a pacemaker, a stimulation electrode, a sensing electrode, and, in some models, an external programmer unit. Respiration sensing is accomplished by the electrodes determining the patient's position at rest/activity to allow for programming of applicable delivery times. This unit assists stable breathing by preventing episodes of apnea followed by rapid breathing. In 0428T, only the pulse generator is removed. The pocket is opened. The generator is disconnected from the electrodes and removed. The electrodes remain within the pocket and the pocket is closed. In 0429T, the sensing electrode is removed. In 0430T, the stimulation electrode is removed. The generator pocket is opened and the electrode is disconnected from the generator. The electrode is dissected from the scar tissue that has formed around it and withdrawn. Bleeding from the tracts leading to the vein is controlled with sutures.

Code range 0432T-0433T and lay description did **not** publish; the correct information is:

0432T-0433T

A previously placed stimulation lead (0432T) or sensing lead (0433T) is repositioned. This is done when the system does not function due to improper placement of the electrode itself. The generator is removed and the electrode is tested to ensure that it is not defective, but simply in the wrong place. It is reattached to the generator in its new position and tested again.

Code range 0434T-0436T and lay description did **not** publish; the correct information is:

0434T-0436T

In 0434T, a periodic interrogation evaluation is performed on a previously implanted neurostimulator device, including a face-to-face assessment of all device functions. Components that must be evaluated include rate parameters, pulse amplitude and duration, waveform configuration, battery, electrode selectability, output modulation, cycling, impedance, and compliance measurements. In 0435T, a programming device evaluation is performed in person in order to test the device's function and select the most favorable permanent programmed values. Patients with previously implanted neurostimulator systems require periodic programming device evaluations. This diagnostic procedure includes a face-to-face assessment of all device functions and is reported for a single session. Report 0436T only once when programming is performed during a sleep study, no matter how many adjustments are made during the study.

- **Page 896**

Code range 0440T-0442T and lay description did **not** publish; the correct information is:

0440T-0442T

Cryoablation of a nerve is performed to relieve chronic nerve pain by damaging the nerve's myelin coating thereby blocking the pain signal to the brain. The patient typically receives conscious sedation during the insertion of the cryoprobe into the nerve causing the pain. With the probe in place, the patient may be further sedated and/or a nerve block is performed with lidocaine. Imaging guidance is utilized to guide the probe placement and verify optimal position. A freezing agent is administered through the probe by way of tubing connecting it to the system distributing liquid nitrogen or argon gas. The system controls the flow of the freezing agent. Upon completion of the procedure, the probe is removed, pressure is applied to stop bleeding, and the skin is bandaged. Report 0440T when an upper extremity distal/peripheral nerve is treated; 0441T when a lower extremity distal/peripheral nerve is treated; and 0442T when a nerve plexus or other truncal nerve is treated.

Code range 0446T-0448T and lay description did **not** publish; the correct information is:

0446T-0448T

Implantable interstitial glucose sensor devices monitor glucose from interstitial fluid (IF), a solution in the body that surrounds cells, just below the skin's surface. A small sensor is implanted under the skin. Glucose information is transmitted wirelessly to a smart transmitter worn by the patient on the upper arm, above where the sensor has been implanted. The Eversense Sensor™ uses a distinct fluorescent, glucose indicating polymer. A light emitting specialized electronic component called a diode attached to the sensor excites the polymer and the polymer quickly detects a change in the glucose concentration by a change in the light display. The IF glucose measurement is communicated to the transmitter, which calculates the glucose and indicates whether that value is going up or down and at what speed. Additionally, the smart transmitter can relay whether the glucose values exceed preset low and high-target values. When the patient opts to use the smartphone app, data and alerts can also be sent in that manner at the same time to permit real-time tracking of data to assist the patient in monitoring and controlling glucose levels. Sensors can be implanted to provide continuous glucose monitoring (CGM) for a period of up to three months. Report 0446T for initial implantation, including creation of the subcutaneous pocket, insertion of the device, activation, and training; 0447T for removal of the interstitial glucose sensor by incision; and 0448T when the device is removed with creation of a subcutaneous pocket at a different anatomic site and another sensor is implanted and activated.

Code range 0449T-0450T and lay description did **not** publish; the correct information is:

0449T-0450T

Aqueous drainage devices reduce intraocular pressure (IOP) in the management of primary open angle glaucoma (POAG), the most common type of glaucoma. POAG is associated with a buildup of aqueous fluid pressure within the eye, which can lead to blindness and damage to the optic nerve. Patients often have no pain or discomfort associated with this and no visible abnormality is seen in the anterior chamber despite the aqueous fluid being unable to flow properly. Drainage devices lower IOP by a process of diverting excess fluid from the anterior chamber to the subconjunctival bleb instead of to an extraocular reservoir or another device that is inserted in the eye during cataract surgery and allows the aqueous fluid from the anterior chamber to flow into the Schlemm's canal toward the episcleral drainage system and away from the trabecular meshwork. Report 0449T for initial insertion of an aqueous drainage device and 0450T for insertion of each additional device.

Code range 0451T-0454T and lay description did **not** publish; the correct information is:

0451T-0454T

Implantable counterpulsation devices are exceeding limitations of traditional left ventricular assist devices (LVAD) by reducing the amount of energy utilized within the left ventricle, pulling on LV reserves for systolic function, improving LV performance, retaining velocity of blood flow, and maintaining heart stability. These devices are built to assist the heart in pumping blood through the body by assisting in the outflow from the left side of the heart into the aorta. The device is inserted in the aorta by creating a subclavian arterial graft and subcutaneous pocket where the mechano-electrical interface is placed. This interface gathers ECG signals and transmits them to the external control unit. The control unit can determine the area of the "dicrotic notch," the moment in the cardiac cycle when pressure dips in conjunction with the closure of the aortic valve, initiating the process of compressed air through the system to inflate the counterpulsation device. Upon diastole conclusion, the device suctions out the air via the same circuit. These devices are for long term use and utilize a vascular graft and hemostatic seal, mechano-electrical skin interface, and subcutaneous electrodes. The Symphony brand device is an example of an implantable device that is deployed endovascularly and sits within a pacemaker like pocket on the right side of the chest. This device incorporates a pump sac connected to the patient's circulation by a vascular graft that is adhered to the subclavian artery. A line is tunneled out through the skin and connected to the control unit or console. Report 0451T for insertion or replacement of the entire system; 0452T for insertion or replacement of the aortic counterpulsation device and vascular hemostatic seal (blocks blood flow and establishes an area allowing the blood to clot); 0453T for insertion or replacement of the mechano-electrical skin interface; and 0454T for insertion or replacement of the subcutaneous electrode.

Code range 0455T-0458T and lay description did **not** publish; the correct information is:

0455T-0458T

In 0455T, the physician removes an implantable aortic counterpulsation ventricular assist system. The pocket is opened. The existing system is disconnected from the electrodes and removed. The device is removed from the aorta, along with all components of the system. The pocket is closed. Report 0456T for removal of the counterpulsation device and vascular hemostatic seal; 0457T for removal of the mechano-electrical skin interface; and 0458T for removal of the subcutaneous electrode.

Code range 0460T-0461T and lay description did **not** publish; the correct information is:

0460T-0461T

The physician repositions the subcutaneous electrode (0460T) or counterpulsation device (0461T). This is done when the system does not function due to improper placement of the electrode or counterpulsation device. The electrode and/or counterpulsation device is tested to ensure they are not defective, but simply in the wrong place. The electrode and/or counterpulsation device is reattached to the interface in its new position and tested again.