CPT® 2024 Code Changes

The following is a listing of new Current Procedural Terminology (CPT®) codes and their descriptors as described in the *CPT® 2024* codebook. This listing covers codes pertinent to Radiology services and is only a portion of all of the CPT® code changes for 2024. For a complete listing of code changes, please refer to the *CPT® 2024* codebook and *CPT® Changes 2024: An Insider's View.*

CPT 2024 CODE SET: NEW CATEGORY I CODES

New Category I radiology codes will be added to the CPT 2024 code set, which will be available on January 1, 2024.

Dorsal Sacroiliac (SI) Joint Arthrodesis

Category III code 0775T has been converted to Category I code 27278 for reporting percutaneous arthrodesis of the SI joint using an intra-articular implant(s) without the placement of a transfixation device across the joint. The new Category I code will allow the reporting of percutaneous intra-articular placement of one or more fusion implant(s) directly into the SI joint under imaging guidance. This is typically performed from a posterior/dorsal approach.

● **27278** Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device

►(For arthrodesis, sacroiliac joint, with placement of a percutaneous transfixation device, use 27279)◄

►(For bilateral procedure, report 27278 with modifier 50)◄

In contrast, existing code 27279 is used to report percutaneous placement of a transfixation device, such as a screw, across the SI joint to perform fusion. This is typically performed from a lateral approach.

27279 Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device

►(For percutaneous arthrodesis of the sacroiliac joint by intra-articular implant[s], use 27278)◄

(For bilateral procedure, report 27279 with modifier 50)

Transcervical Radiofrequency Ablation (RFA) of Uterine Fibroids

Category III code 0404T has been converted to Category I code 58580 to report transcervical RFA of uterine fibroids, which includes intraoperative ultrasound guidance

and monitoring. This minimally invasive procedure includes real-time intrauterine ultrasound guidance for the treatment of symptomatic uterine fibroids (ie, leiomyomas).

● **58580** Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency

►(Do not report 58580 in conjunction with 58561, 58674, 76830, 76940, 76998)◄

►(For laparoscopic radiofrequency ablation of uterine fibroid[s], including intraoperative ultrasound guidance and monitoring, use 58674)◄

Coronary Fractional Flow Reserve (FFR) with Computed Tomography (CT)

Category III codes 0501T, 0502T, 0503T, and 0504T (coronary FFR with CT) have been deleted and replaced with a single Category I code (75580) to describe noninvasive estimated coronary FFR derived from augmentative artificial intelligence software analysis of coronary CT angiography (CCTA) data.

● **75580** Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional

►(Use 75580 only once per coronary computed tomography angiogram)◄

►(When noninvasive estimate of coronary FFR derived from augmentative software analysis of the data set from a coronary computed tomography angiography with interpretation and report by a physician or other qualified health care professional is performed on the same day as the coronary computed tomography angiography, use 75580 in conjunction with 75574)◄

Coronary Intravascular Lithotripsy (IVL) Interventions

New add-on code +92972 will replace Category III code 0715T to describe percutaneous transluminal coronary lithotripsy, a revascularization technique used to treat heavily calcified coronary arteries using pulsatile sonic pressure waves that pass through soft tissue and selectively interact with high-density calcium to produce shear stresses that fracture the calcium.

#+● **92972** Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)

►(Use 92972 in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975)◄

Cardiac Intraoperative Ultrasound (IOUS) Services

Codes 76984, 76987, 76988, 76989 will be available to report cardiac IOUS, which are used primarily in cardiothoracic surgery procedures, including epiaortic ultrasound and congenital epicardial echocardiography. Cardiac IOUS are useful with evaluating cardiovascular structures, providing intraoperative guidance, and real-time perioperative surgical decision-making information that may affect the operative strategy (eg, changing cannulation strategies, altering bypass targets, and identifying additional defects).

● **76984** Ultrasound, intraoperative thoracic aorta (eg, epiaortic), diagnostic

►(For diagnostic intraoperative epicardial cardiac ultrasound [ie, echocardiography], see 76987, 76988, 76989)◄

● **76987** Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report

● **76988** placement, manipulation of transducer, and image acquisition only

● **76989** interpretation and report only

►(For diagnostic intraoperative thoracic aorta ultrasound [eg, epiaortic], use 76984)◄

CPT 2024 CODE SET: NEW CATEGORY III CODES

Several Category III codes have been established in the CPT 2024 code set that will be available on January 1, 2024. They are summarized as follows.

Quantitative MRI Analysis of the Brain with Comparison

Two new Category III codes (0865T and 0866T) have been created to report quantitative magnetic resonance image (MRI) analysis of the brain, a new technology that uses software to identify diseased areas of the brain by generating quantitative information on lesion number, volume(s), and location(s). The results are compared with previous scans to determine changes in disease activity in the brain.

● **0865T** Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session

+● **0866T** Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission,

interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)

►(Use 0866T in conjunction with 70551, 70552, 70553)◄

►(For quantitative MR for analysis of tissue composition, see 0648T, 0649T, 0697T, 0698T)◄

►(For quantitative computed tomography tissue characterization, see 0721T, 0722T)◄

►(For quantitative MRI analysis of the brain without comparison to prior MR study, report 0865T, 0866T with modifier 52)◄

Injection of Calcium-Based Implant

A new Category III code (0814T) will be available to report percutaneous injection of calcium-based biodegradable osteoconductive material, a procedure performed by implanting triphasic, calcium-based, osteoconductive material under imaging guidance into the femoral cortex to form new bone in voids in the proximal femur of patients with disorders such as osteoporosis.

● **0814T** Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral

►(Do not report 0814T in conjunction with 26992, 77002)◄

Ultrasound-Based Radiofrequency Echographic Multi-Spectrometry (REMS)

Code 0815T has been created to report ultrasound-based REMS to assess bone density and fracture risk for one or more sites (eg, hips, pelvis, or spine) providing an alternative to the current bone-density assessment, dual-energy X-ray absorptiometry (DXA) codes, which uses ionizing radiation.

● **0815T** Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine

Opto-Acoustic Imaging

A new add-on code (+0857T) will be available to report opto-acoustic imaging for breast masses. This technology uses light pulses to create ultrasound waves via the photoacoustic effect, creating a real-time opto-acoustic image allowing for a different method of evaluating breast masses and potentially reduces false positives and subsequent breast biopsies than ultrasound alone.

Note that code +0857T should be reported with breast ultrasound code 76641 or 76642.

+● **0857T** Opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis and report (List separately in addition to code for primary procedure)

►(Use 0857T in conjunction with 76641, 76642)◄

Evaluation and Management (E/M)

As part of the work of the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) to decrease the administrative burden of documentation, the following changes have been made in the E/M section:

- Time ranges in office or other outpatient visit codes 99202-99205 and 99212-99215 have been replaced with time thresholds that align with other E/M codes.
- Guidance regarding physician services that may be reported for split (or shared) visits has been added.
- Reporting instructions have been added for codes 99234-99236 (hospital inpatient or observation care services, including admission and discharge services) when the duration of the visit crosses over two calendar dates.

For specific changes, refer to the CPT 2024 code book.

Telemedicine Office Visits

A new E/M subsection with new guidelines for telemedicine services will be available in the CPT 2024 code set. The new codes will be similar to the existing E/M office or other outpatient services code structure (ie, using time or medical decision making [MDM]) with separate codes for new and established patient encounters and a virtual check-in code that would be used to evaluate whether a patient needs a face-to-face visit. Existing codes 99441-99443 will be deleted.

For additional information, refer to Appendices P and T in the CPT 2024 code book.

DELETED CODES

The following codes have been deleted from the CPT 2024 code set:

99441 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99442 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

99443 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating

from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

0404T Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency

0501T Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report

0502T Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission

0503T Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model

0504T Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report

+0715T Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)

0775T Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s])

REVISED CODES

The following E/M codes have been revised in the CPT 2024 code set.

New Patient

★▲ **99202** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

★▲ **99203** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

★▲ **99204** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

★▲ **99205** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Established Patient

★▲ **99212** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

★▲ **99213** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

★▲ **99214** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

★▲ **99215** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.