2017 CPT Code Update

A number of new codes and guideline revisions will be implemented for 2017. As in past years, new codes have been created as a result of bundling mandates from the AMA’s Relativity Assessment Workgroup (RAW) for the purpose of identifying potentially misvalued services. Code pairs identified as being performed together 75 percent or more of the time and, therefore, referred to the CPT® Editorial Panel for bundling in 2017 include dialysis circuit intervention and open and percutaneous transluminal angioplasty (PTA) procedures.

New codes also will be introduced to describe procedures that are currently not described within the CPT code set, such as cryoablation for phantom limb pain. In addition, category III codes to describe computer-aided detection for breast MRI and chest have been extended, and a number of Category III codes have been deleted.

For 2017, note that the moderate (conscious) sedation codes have been revised and moderate sedation will no longer be bundled into the base procedure code.

The ACR urges its members to be sure to update their coding and billing files to reflect the changes effective Jan. 1, 2017 and to refer to the CPT 2017 codebook for a complete listing of codes, guidelines and parenthetical changes.

Diagnostic Radiology

**Fluoroscopy [77002, 77003 revisions]**

+77002  Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure) (See appropriate surgical code for procedure and anatomic location) (Use 77002 in conjunction with 10022, 10160, 20206, 20220, 20225, 20520, 20525, 20526, 20550, 20551, 20552, 20553, 20555, 20600, 20605, 20610, 20612, 20615, 21116, 21550, 23350, 24220, 25246, 27093, 27095, 27370, 27648, 32400, 32405, 32553, 36002, 38220, 38221, 38505, 38794, 41019, 42400, 42405, 47000, 47001, 48102, 49180, 49411, 50200, 50390, 51100, 51101, 51102, 55700, 55876, 60100, 62268, 62269, 64505, 64508, 64600, 64605) (77002 is included in all arthrography radiological supervision and interpretation codes. See Administration of Contrast Material[s] introductory guidelines for reporting of arthrography procedures)

+77003  Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure) (Use 77003 in conjunction with 61050, 61055, 62267, 62270, 62272, 62273, 62280, 62281, 62282, 62284, 64510, 64517, 64520, 64610) (Do not report 77003 in conjunction with 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327)
For 2017 the global period assignments for fluoroscopic guidance codes 77002 (for needle placement (e.g., biopsy, aspiration, injection, localization device)) and 77003 (for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)) have been assigned a ZZZ global value [code related to another service and is always included in the global period of the other service]. Currently, these codes are classified as stand-alone XXX codes [global concept does not apply]. The ACR agreed with the Centers for Medicare and Medicaid Services (CMS) that the 77002 and 77003 vignettes and the CPT codebook parentheticals are consistent with an add-on code structure similar to 77001 (Fluoroscopic guidance for central venous access device placement, replacement...[List separately in addition to code for primary procedure]).

**Mammography + Computer-Aided Detection**

77065  Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral

77066  bilateral

77067  Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed (For electrical impedance breast scan, use 76499)

New codes have been established that bundle computer-aided-detection (CAD) with mammography. The current CAD and mammography codes 77051, 77052, 77055, 77056, and 77057 will be deleted in 2017. It is also anticipated that the HCPCS Level II G codes G0202, G0204 and G0206 will be deleted, as the new mammography codes refer to either digital or analog procedures. The Final Rule of the Medicare Physician Fee Schedule due out in November will list whether or not these “G” codes are to be deleted in 2017.

**Ultrasound - screening study for abdominal aortic aneurysm (AAA)**

76706  Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA) (For ultrasound or duplex ultrasound of the abdominal aorta other than screening, see 76770, 76775, 93978, 93979)

Healthcare Common Procedure Coding System (HCPCS) Level II code G0389, Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening will be deleted and replaced with CPT Category I code 76706. Code G0389 was identified as a potentially misvalued code and after review by the RAW at the September 2014 Relative Value Scale Update Committee (RUC) meeting, the RUC sent this issue back to CPT. A CPT multispecialty society workgroup requested a CPT Category I code.
Interventional Radiology

**Mechanochemical (MOCA) Vein Ablation**

36473  *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated*

+36474  *subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)*

*(Use 36474 in conjunction with 36473)*

*(Do not report 36474 more than once per extremity)*

*(Do not report 36473, 36474 in conjunction with 29581, 29582, 36000, 36002, 36005, 36410, 36425, 36475, 36476, 36478, 36479, 37241, 75894, 76000, 76001, 76937, 76942, 76998, 77022, 93970, 93971 in the same surgical field)*

*(For catheter injection of sclerosant without concomitant endovascular mechanical disruption of the vein intima, use 37799)*

*(For catheter injection of an adhesive, use 37799)*

Two new codes to report non-tumescent, mechanochemical treatment of extremity vein incompetence will be created and the current codes 36476 and 37479 will be revised to describe the additional veins treated. Codes 36473-36479 include imaging guidance and monitoring as noted in the descriptors. Codes 36474 and 36479 should only be reported once for subsequent veins treated in the same extremity regardless of the number of veins treated. See the CPT 2017 codebook for additional coding guidelines.

**Dialysis Circuit Access**

36901  *Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;*

*(Do not report 36901 in conjunction with 36833, 36902, 36903, 36904, 36905, 36906)*

36902  *with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty*

*(Do not report 36902 in conjunction with 36903)*

36903  *with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment*
(Do not report 36902, 36903 in conjunction with 36833, 36904, 36905, 36906)
(Do not report 36901, 36902, 36903 more than once per operative session)
(For transluminal balloon angioplasty within central vein(s) when performed through dialysis circuit, use 36907)
(For transcatheter placement of intravascular stent(s) within central vein(s) when performed through dialysis circuit, use 36908)

36904  Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);
(For open thrombectomy within the dialysis circuit, see 36831, 36833)

36905  with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty
(Do not report 36905 in conjunction with 36904)

36906  with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit
(Do not report 36906 in conjunction with 36901, 36902, 36903, 36904, 36905)
(Do not report 36904, 36905, 36906 more than once per operative session)
(For transluminal balloon angioplasty within central vein(s) when performed through dialysis circuit, use 36907)
(For transcatheter placement of intravascular stent(s) within central vein(s) when performed through dialysis circuit, use 36908)

+36907  Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)
(Use 36907 in conjunction with 36818-36833, 36901, 36902, 36903, 36904, 36905, 36906)
(Do not report 36907 in conjunction with 36908)
(Report 36907 once for all angioplasty performed within the central dialysis segment)

+36908  Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)
(Use 36908 in conjunction with 36818-36833, 36901, 36902, 36903, 36904, 36905, 36906)
(Do not report 36908 in conjunction with 36907)
(Report 36908 once for all stenting performed within the central dialysis segment)

+36909 Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)
(36909 includes all permanent vascular occlusions within the dialysis circuit and may only be reported once per encounter per day)
(Report 36909 in conjunction with 36901, 36902, 36903, 36904, 36905, 36906)
(For open ligation/occlusion in dialysis access, use 37607)

Dialysis circuit angiography, angioplasty, stent placement, thrombectomy and embolization bundled codes were created to reflect the work related to dialysis circuit diagnosis and interventions. Codes 35471, 35472, 35475, 35476, 36147, 36148, 36870, and 75791 will be deleted as a number of these codes were identified by the RAW as being frequently reported together in various combinations. See extensive coding guidelines in the CPT 2017 codebook.

Open and Percutaneous Transluminal Angioplasty PTA

37246 Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery

+37247 each additional artery (List separately in addition to code for primary procedure)
(Use 37247 in conjunction with 37246)
(Do not report 37246, 37247 in conjunction with 37215, 37216, 37217, 37218, 37220-37237 when performed in the same artery during the same operative session)
(Do not report 37246, 37247 in conjunction with 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848 for angioplasty(ies) performed, when placing bare metal or covered stents into the visceral branches within the endoprosthesis target zone)

37248 Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein
New bundled codes 37246-37249 now describe transluminal balloon angioplasty and the associated radiologic imaging services. These angioplasty codes are now differentiated by whether performed on an artery or vein. Previously, they were differentiated by vessel treated and the approach used. Introductory note guidelines and parentheticals following the codes provide details on how to use these codes.

The current codes for percutaneous (35471, 35472, 35475, 35476) and open (35450, 35452, 35458, 35460) transluminal balloon angioplasty and the associated radiologic imaging services codes (75962, 75964, 75966, 75968, 75978) will be deleted.

**Interlaminar Epidural or Subarachnoid Injections**

**62320** Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

**62321** with imaging guidance (ie, fluoroscopy or CT)
(Do not report 62321 in conjunction with 77003, 77012, 76942)

**62322** Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance

**62323** with imaging guidance (ie, fluoroscopy or CT)
(Do not report 62323 in conjunction with 77003, 77012, 76942)
62324  Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

62325  with imaging guidance (ie, fluoroscopy or CT)
(Do not report 62325 in conjunction with 77003, 77012, 76942)

62326  Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

62327  with imaging guidance (ie, fluoroscopy or CT)
(Do not report 62327 in conjunction with 77003, 77012, 76942)
(Report 01996 for daily hospital management of continuous epidural or subarachnoid drug administration performed in conjunction with 62324, 62325, 62326, 62327)

Codes 62310, 62311, 62318 and 62319 will be deleted and replaced by injection codes 62320-62327. The new codes are now differentiated by spinal region and whether performed with or without imaging guidance. Detailed coding guidelines are provided in the CPT 2017 codebook.

**Moderate (Conscious) Sedation**

99151  Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age

99152  initial 15 minutes of intraservice time, patient age 5 years or older

+99153  each additional 15 minutes intraservice time (List separately in addition to code for primary service)
(Use 99153 in conjunction with 99151, 99152)
(Do not report 99153 in conjunction with 99155, 99156)

99155  Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation
supports; initial 15 minutes of intraservice time, patient younger than 5 years of age

99156  initial 15 minutes of intraservice time, patient age 5 years or older

+99157  each additional 15 minutes intraservice time (List separately in addition to code for primary service)
         (Use 99157 in conjunction with 99155, 99156)
         (Do not report 99157 in conjunction with 99151, 99152)

The current moderate (conscious) sedation codes 99143-99145 and 99148-99150, which describe these services in 30 and 15 minute increments, will be deleted and replaced with six new codes to describe moderate sedation provided by a physician, non-physician or other qualified health care professional in 15 minute increments. Extensive guidelines to clarify the use of these codes are provided in the CPT 2017 codebook. Note that the moderate sedation (©) symbol and Appendix G have been removed from the CPT 2017 codebook. When moderate sedation is performed and meets the guidelines for use, it will be reported separately in conjunction with the CPT procedure code in 2017.

Category III Codes

New Category III Codes (Codes were effective July 1, 2016 and will appear in the CPT 2017 codebook.)

0438T  Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance

0440T  Ablation, percutaneous, cryoablation, including imaging guidance; upper extremity distal/peripheral nerve

0441T  lower extremity distal/peripheral nerve

0442T  nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)

A new Category III code will be created to describe percutaneous cryoablation for phantom limb pain. Category III codes allow for more appropriate documentation and tracking of the use of emerging technologies.

Deletion of Category III Codes

0169T  Stereotactic placement of infusion catheter(s) in the brain for delivery of therapeutic agent(s), including computerized stereotactic planning and burr hole(s)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0281T</td>
<td>Percutaneous transcatheter closure of the left atrial appendage with implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, radiological supervision and interpretation</td>
</tr>
<tr>
<td>0282T</td>
<td>Percutaneous or open implantation of neurostimulator electrode array(s), subcutaneous (peripheral subcutaneous field stimulation), including imaging guidance, when performed, cervical, thoracic or lumbar; for trial, including removal at the conclusion of trial period</td>
</tr>
<tr>
<td>0283T</td>
<td>permanent, with implantation of a pulse generator</td>
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<tr>
<td>0284T</td>
<td>Revision or removal of pulse generator or electrodes, including imaging guidance, when performed, including addition of new electrodes, when performed</td>
</tr>
<tr>
<td>0285T</td>
<td>Electronic analysis of implanted peripheral subcutaneous field stimulation pulse generator, with reprogramming when performed</td>
</tr>
<tr>
<td>0286T</td>
<td>Near-infrared spectroscopy studies of lower extremity wounds (eg, for oxyhemoglobin measurement)</td>
</tr>
<tr>
<td>0287T</td>
<td>Near-infrared guidance for vascular access requiring realtime digital visualization of subcutaneous vasculature for evaluation of potential access sites and vessel patency</td>
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</tbody>
</table>

With the deletion of the above Category III codes in 2017, coders are referred to the unlisted procedure codes for reporting.

**Category III Codes Extended**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0159T</td>
<td>Computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0174T</td>
<td>Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0175T</td>
<td>Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation</td>
</tr>
</tbody>
</table>
The above radiology Category III codes were marked to be retired in 2017. However, based on specialty society input these codes will be extended until the procedures have met the criteria for CPT Category I code status.

The ACR’s July 22, 2016 Advocacy in Action eNews posted an impact analysis of the 2017 code changes based on the CMS Medicare Physician Fee Schedule (MPFS) and Hospital Outpatient Prospective Payment System (HOPPS) proposed rules. An updated impact analysis will be posted on the ACR website in mid-November. The CMS-approved values for codes will not be known until the MPFS Final Rule is published in the Federal Register, typically in early November. See the November/December ACR Radiology Coding Source for links to the Final Rule, and be sure to reference the AMA’s CPT 2017 codebook, CPT Changes: 2017 An Insider’s View, and the AMA/ACR’s Clinical Examples in Radiology for more detailed information on the appropriate use of the new 2017 radiology codes.