2010 CPT® Code Update
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To assist in preparation for the new CPT coding year beginning January 1, 2010, the American College of Radiology (ACR) offers the following highlights of major code changes that will affect radiology practices. A number of new bundled codes have been created as requested by the CPT/RUC Five-Year Identification Workgroup. These bundled codes are for high volume procedures that have been identified as possibly being misvalued, as they are performed together greater than 95 percent of the time. For a complete listing of CPT 2010 code changes, please see the CPT 2010 code book and CPT Changes 2010: An Insider’s View.

*[The Health Insurance Portability and Accountability Act transaction and code set rules require the use of the medical code set that is valid at the time the service is provided. There is no grace period given to implement these changes (Pub 100-04, Medicare Claims Processing Manual, Transmittal 89).*]

**Diagnostic Radiology**

**Computed Tomographic Colonography – 74261-74263**

In place of the current two Category III codes (0066T and 0067T) to describe computed tomographic colonography (CTC), three Category I codes have been created: two codes to describe a diagnostic CTC study performed either without contrast (74261) or with contrast, including noncontrast images if performed (74262); and one code to describe a screening CTC study (74263).

A noncontrast CTC diagnostic study is of value in those patients for whom an instrument colonoscopy of the entire colon is incomplete due to an obstructing neoplasm resulting in an inability to pass the colonoscope proximally. A contrast-enhanced diagnostic study may be useful in some patients after incomplete endoscopy to characterize indeterminate colonic masses or to better visualize colonic segments with excess fluid.

The new CTC descriptor includes the phrase “including image postprocessing,” to clarify that both two-dimensional and three-dimensional rendering is included and not reported separately. In order to report one of these CTC codes, interpretation of the entire exam (i.e., both intra- and extraluminal evaluation) must take place.

These new codes were developed through a CPT Editorial Panel appointed workgroup, which included the radiology and gastroenterology specialty societies.
Cardiac Computed Tomography and Coronary Computed Tomographic Angiography – 75571-75574

The ACR and the American College of Cardiology (ACC) requested the creation of four new all-inclusive Category I procedure codes (75571, 75572, 75573, and 75574) to replace the current eight Category III codes (0144T-0151T). These four new codes describe the typical cardiac computed tomography (CCT) and coronary computed tomographic angiography (CCTA) procedures that are being performed today with significant frequency.

The four new codes are differentiated by cardiac CT without contrast (75571), cardiac CT with contrast (75572), cardiac CT with contrast in a patient with congenital heart disease (75573), and coronary CT angiography (75574). A distinct code for a CCTA study for a patient with known or suspected congenital heart disease (75573) was created because of the extra physician work involved in the level of postprocessing, interpretative skill, supervision of patient preparation and image acquisition.

CCT and CCTA include the axial source images of the pre-contrast, arterial phase sequence, and venous phase sequence (if performed), as well as the two-dimensional and three-dimensional reformatted images resulting from the study, including cine review. Contrast-enhanced coronary CTA codes 75572-75574 include any quantitative assessment [calcium scoring] when performed as part of the same encounter. The CPT guidelines note that only one of these codes may be reported per encounter.

Cardiac Flow Velocity Mapping – 75565

In 2008, eight new codes were developed to describe cardiac magnetic resonance imaging (75557-75564). However, because codes 75558, 75560, 75562, and 75564 include cardiac magnetic resonance imaging (CMRI) blood flow measurement, Medicare had denied payment for the entire CMRI procedure based on an old national non-coverage determination of blood flow measurements. The ACR and other specialty societies worked together to address this through both the CPT process and changes in Medicare coverage policy.

Add-on code 75565 (Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure) will be available as of January 1, 2010 to describe this procedure. This code is to be used in conjunction with code 75557, 75559, 75561 or 75563. Only one code in the 75557-75563 may be reported per session, and only one flow velocity measurement may be reported per session.
In addition, the ACR and other specialty societies asked that the Medicare national non-coverage determination be revised. On September 28, 2009, the Centers of Medicare and Medicaid Services revised its long-standing non-coverage policy and now allows local Medicare carriers and Medicare administrative contractors to determine whether or not they will cover CMRI flow velocity mapping.

For 2009, practices that perform flow velocity measurement services should continue to use code 75558, 75560, 75562 or 75564, as they accurately describe the procedure performed. ACR staff are working through the Carrier Advisory Committee networks to obtain coverage at the local level for the CMRI blood flow mapping portion of this procedure.

**Interventional Radiology**

**Arteriovenous Shunt for Dialysis Catheter – 36147, 36148, 75791**

The component codes 36145 (*Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)*) and 75790 (*Angiography, arteriovenous shunt (eg, dialysis patient), radiologic supervision and interpretation*) will be deleted and two new bundled codes created to describe the initial access (36147) and each additional access (36148) for both the introduction of the catheter and the radiological supervision and interpretation (RS&I). The combined codes were created at the request of the RUC Five-Year Identification Workgroup based on claims data that showed these procedures were performed together greater than 95% of the time.

In addition, a new stand-alone arteriovenous (AV) shunt angiography RS&I code (75791) was created. This new code should be reported only when fistulography (RS&I) is performed through an already existing access into the shunt or from an access that is not a direct puncture of the shunt. It should not be reported with the new bundled codes 36147 or 36148, which already include the work and resources of RS&I. In the unusual instance where fistulography leads to a new access, 36147 should be reported.

**Facet Joint Injection Revisions**

Facet joint injection codes 64470, 64472, 64475, and 64476 will be deleted and replaced by six new codes 64490-64495. The new codes will be placed in a new subsection of the CPT code book titled *Paravertebral Spinal Nerves and Branches*. The current four codes which are differentiated by cervical or thoracic (64470), lumbar or sacral (64475), each additional cervical/thoracic (64472) and each additional lumbar/sacral level (64475), will now be described by six new codes differentiated by cervical or thoracic, single level (64490), lumbar or sacral,
single level (64493), as well as by second level (64491, 64494), and third and any additional level(s) (64492, 64495). The codes are used for both diagnostic and therapeutic agent injections for the paravertebral facet joint or nerves innervating that joint and include fluoroscopic or CT image guidance and any injection of contrast. These codes refer to unilateral injections, therefore, when a bilateral procedure of a level is reported, the bilateral modifier (-50) should be reported. When the T12-L1 joint is injected, code 64493 (lumbar or sacral level) should be reported as this would be considered one level. Because codes 64490-64495 include imaging, when imaging is not used, the injection codes 20550-20553 should be reported.

Because fluoroscopic guidance is included in the bundled paravertebral facet joint injection code, the descriptor for the fluoroscopic guidance code 77003 will delete the reference to report 77003 in conjunction with the paravertebral facet joint and paravertebral facet joint nerve codes.

Note that ultrasound guidance is not included in the paravertebral facet joint injection procedure descriptor; therefore, if ultrasound-guidance is used in place of fluoroscopic or CT guidance, one of the newly created bundled ultrasound-guided paravertebral facet joint injection procedure codes, 0213T-0218T (see AMA Web site) should be reported as of January 1, 2010. Category III codes have been assigned until the criteria for category I status are met.

**Removal of Indwelling Tunneled Pleural Catheter with Cuff - 32552**

Initially, when code 32550 was created, an indwelling tunneled pleural catheter with cuff was inserted for drainage and management of malignant pleural effusions at the end of a patient’s life; therefore, the removal of the catheter was not included in the valuation of 32550. Currently, when a catheter with cuff is removed, either an evaluation and management code, or the unlisted procedure code 32999 is reported. Because 32550 does not include the incisions and subcutaneous dissection of the indwelling cuff necessary to remove the catheter, code 32552 was created to accurately reflect the work involved. As of January 1, 2010, code 32552 should be used to describe the removal, and code 32550 should continue to be used to describe the insertion of an indwelling tunneled pleural catheter with cuff.

**Placement of Interstitial Devices for radiation Therapy Guidance - 32553, 49411, 55876**

Two new codes were created to describe the percutaneous placement of an interstitial device(s), such as a fiducial marker or dosimeter, for radiation therapy guidance within the thorax (32553), and within the abdomen, pelvis and/or retroperitoneum (49411). As with the placement of an interstitial device(s) in the prostate, imaging guidance (76942, 77002, 77012, 77021) and the device(s) are
coded in addition to the procedure codes (32553, 49411, 55876). For example, HCPCS Level II codes used to report devices include: A4648, Tissue marker, implantable, any type, each; A4650, Implantable radiation dosimeter, each; and A4649, Surgical supply; miscellaneous.

The descriptor for code 55876 was editorially revised to specify Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, prostate, single or multiple. The term "percutaneous" replaced the current phrase "via needle, any approach" to be consistent with the above newly created descriptors. Note: this code should continue to be reported to describe the transrectal approach for placement of fiducial markers in the prostate.

**Instillation, via chest tube/catheter, agent for fibrinolysis - 32561-32562**

Two new codes (32561-32562) were created to describe instillation of an agent for fibrinolysis and to differentiate it from that of instillation of an agent for pleurodesis (32560).

The instillation of a fibrinolytic agent may be performed on a patient multiple times per day over a course of several days. Code 32561 is to be reported only once on the initial day of treatment, and code 32562 is to be reported only once on each subsequent day of treatment.

With the establishment of codes 32561 and 32562, the descriptor of code 32560, Chemical pleurodesis (eg for recurrent or persistent pneumothorax), will be editorially revised to specify Instillation, via chest tube/catheter agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax).

**Moderate Sedation Codes**

A number of current CPT codes will be designated as including moderate sedation and, therefore, sedation should not be coded separately. They include:

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**Nuclear Medicine**

**Myocardial Perfusion Imaging - 78451-78454**

Myocardial perfusion imaging (MPI) codes 78460, 78461, 78464, and 78465, wall motion code 78478, and ejection fraction code 78480 will be deleted and replaced by four new codes, 78451-78454, to describe myocardial perfusion imaging studies which bundle in wall motion and ejection fraction. A revision to the code structure was requested by the RUC Five-Year Identification Workgroup
as wall motion and ejection fraction were identified as being performed greater than 95% of the time during myocardial perfusion studies.

As of January 2010, wall motion and ejection fraction, when performed, will be considered part of the myocardial perfusion study code and not reported separately. The 2010 guidelines note that the new myocardial perfusion codes include any method to determine the left ventricular ejection fraction and wall motion when codes 78451-78454 are reported, whether it be from the gated-SPECT data or from the first pass data upon injection of the radiopharmaceutical for the myocardial perfusion study. Therefore, when wall motion and ejection fraction are assessed by a first-pass technique (78481,78483) during a myocardial perfusion study, do not report 78481 or 78483 in conjunction with the new MPI codes (78451-78454), as they are part of the MPI procedure.
 Radiation Oncology

*Design and Construction of Multileaf Collimator (MLC) Device(s) - 77338*

Code 77338 was developed to describe the work and practice expense unique to the design and construction of a multileaf collimator device used in conjunction with intensity modulated radiation therapy (IMRT). Code 77418 (IMRT delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session) covers the practice expense for the MLC device, but not for the work and practice expense associated with the design and construction of the MLC device. Therefore, a new code was created to describe this work.

Note that this code should be reported only once per IMRT plan* regardless of the number of plan adjustments. It should not be reported in conjunction with 0073T (Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session).

*Updated 12/09/09 – to agree with CPT 2010 Code Book that states reported once per IMRT plan.
Category III Code Changes

The following new radiology Category III codes were developed in 2009 and will be listed in the 2010 CPT code book: 0197T, infra-fraction localization (implemented January 2009); and sacroplasty codes 0200T (unilateral injection(s)), and 0201T, (bilateral injections) (implemented July 2009). In addition, there are a number of Category III codes, which are to be implemented January 1, 2010, that will not be listed in the 2010 CPT code book, as they were approved too late in the year to be included in the 2010 publication. For example, codes 0213T-0218T that describe ultrasound-guided paravertebral facet joint injection procedures were posted on the AMA Web site in July 2009, and will be implemented in January 2010.

Category III codes set to be archived (not available for use) as of January 1, 2010 include code 0062T and 0063T, which describe percutaneous intradiscal annuloplasty studies. The unlisted procedure code 22899 (Unlisted procedure, spine) should be reported in 2010 when this type of procedure is performed. Also, CT colonography codes (0066T and 0067T) and cardiac CT and coronary CTA codes (0144T-0151T), will be replaced by new category I codes as listed above.

It is important that radiology practices check the AMA Web site twice a year in January and July for the newest Category III codes to be implemented, as some become active before they are listed in the CPT code book.

The usual implementation period between the release of the codes on the Internet (ie, January and July) and the effective date is six months to allow payers to include the codes in their systems. These codes are published twice a year: July 1 releases will be implemented January 1; January 1 releases will be implemented July 1.2

Category II Code Proposed Changes for 2010

No new Category II codes have been developed for radiology for use in 2010. However, there are two proposed revisions. CMS is proposing to revise Measure #11, Stroke and Stroke Rehabilitation: Carotid Imaging Reports; and Measure #10, Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports. Measure #11 will not be limited to patients with stroke, and Measure #10 will clarify the confusion with the guideline “within 24 hours of arrival at hospital.” Click here for a summary of the 2010 PQRI proposed changes. Please direct any questions you have on PQRI to P4Pquestions@acr.org.

Cross References/Editorial Revisions
A number of cross references and editorial revisions have been added to the 2010 CPT code book.

For example, the cross reference following 19295 (*Placement of metallic localization clip*) will specify it is appropriate to report this code in conjunction with the fine needle aspiration code 10022. The RS&I codes for percutaneous vertebral augmentation (vertebroplasty and kyphoplasty) 72291 and 72292 will be revised to specify that these codes also describe sacral augmentation (sacroplasty) and are to be used in conjunction with the Category III codes 0200T and 0201T implemented in July 2009.

For a complete listing of cross-reference updates, as well as CPT code changes for 2010, refer to the *CPT 2010* code book and *CPT Changes: An Insider's View 2010, and the Fall 2009 Bulletin of the AMA/ACR Clinical Examples in Radiology.*

1*CPT Changes 2010: An Insider’s View.*
2*AMA Web site.*, CPT® Category III Codes Release and Effective Dates.