2015 CPT® Code Update

The ACR, either alone or in conjunction with other specialty societies, worked on a number of code proposals for the 2015 code cycle. This update provides a listing of code changes approved for 2015.

Radiology and radiation oncology code pairs identified as being performed together 75 percent or more of the time and, therefore, considered by the CPT Editorial Panel for bundling (as expected by the Centers for Medicare and Medicaid Services (CMS)) in 2015 included dual-energy X-ray absorptiometry, myelography, vertebroplasty and isodose calculation and planning.

The Economics & Health Policy eNews section of the ACR website has posted an impact analysis of the 2015 code changes to help practices prepare for the 2015 changes based on the proposed rule. Note an updated impact analysis will be posted on the ACR website in mid-November after the Medicare Physician Fee Schedule Final Rule is released.

Diagnostic Radiology

Breast Ultrasound

76641 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
76642 limited

The breast ultrasound code 76645 was captured in the Relativity Assessment Workgroup (RAW) screen of codes with a CMS/Other Time Source and Medicare Utilization Greater Than 500,000. Rather than resurvey the existing code, the ACR chose to create two new codes (76641, 76642) to describe a unilateral complete and limited ultrasound, respectively. Code 76641 represents a complete ultrasound examination of the breast. The complete code refers to an examination of all four quadrants of the breast and the retroareolar region. It also includes ultrasound examination of the axilla, if performed. Anything less would be considered limited (76642). The current breast ultrasound code 76645 will be deleted.

Breast Tomosynthesis

77061 Digital breast tomosynthesis; unilateral
77062 bilateral
(Do not report 77061, 77062 in conjunction with 76376, 76377, 77057)
+77063 Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)
(Do not report 77063 in conjunction with 76376, 76377, 77055, 77056)
(Use 77063 in conjunction with 77057)

Multiple radiology societies requested three new Category I codes to describe diagnostic (77061 and 77062) and screening (77063) digital breast tomosynthesis procedures. Current mammography codes do not include the added physician work or practice expense involved in digital breast tomosynthesis and, therefore, new codes were needed to describe these additional resources. Currently under the CMS FAQ issued in November 2013, tomosynthesis is not separately billable. The publication of Medicare’s Final Rule for 2015 this November will, we hope, clarify billing for tomosynthesis.

Dual-Energy X-ray Absorptiometry (DXA)

77085 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment
(Do not report 77085 in conjunction with 77080, 77086)
77086  Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)
(Do not report 77086 in conjunction with 77080, 77085)

The dual-energy x-ray absorptiometry bone density study (77080) and vertebral fracture assessment (77082) codes were identified as codes reported together 75 percent or more of the time. A multispecialty workgroup requested the deletion of code 77082, Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment, and establishment of two new codes to describe DXA and vertebral fracture assessment via dual-energy x-ray absorptiometry (77085) and vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA) (77086).

Interventional Radiology

Cryoablation for Bone and Liver Tumors

20983  Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation
(Do not report 20982, 20983 in conjunction with 76940, 77002, 77013, 77022)

47383  Ablation, 1 or more liver tumor(s), percutaneous, cryoablation
(For imaging guidance and monitoring, see 76940, 77013, 77022)

Two new CPT codes to describe percutaneous cryosurgical ablation of bone (20983) and liver (47383) tumors will be created for 2015 to reflect substantial clinical experience and published clinical trial data documenting the clinical benefits of cryosurgical ablation of bone and liver tumors. Currently, these procedures are reported with an unlisted code.

In addition to the establishment of 20983 to describe cryosurgical ablation of bone tumors, the percutaneous radiofrequency ablation therapy code 20982 will be revised to include adjacent soft tissue when involved by tumor extension, and imaging guidance when performed.

Myelography

62302  Myelography via lumbar injection, including radiological supervision and interpretation; cervical
(Do not report 62302 in conjunction with 62284, 62303, 62304, 62305, 72240, 72255, 72265, 72270)

62303  thoracic
(Do not report 62303 in conjunction with 62284, 62302, 62304, 62305, 72240, 72255, 72265, 72270)

62304  lumbosacral
(Do not report 62304 in conjunction with 62284, 62302, 62303, 62305, 72240, 72255, 72265, 72270)

62305  2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)
(Do not report 62305 in conjunction with 62284, 62302, 62303, 62304, 72240, 72255, 72265, 72270)
(For myelography lumbar injection and imaging performed by different physicians or other qualified health care professionals, see 62284 or 72240, 72255, 72265, 72270)
(For injection procedure at C1-C2, use 61055)

The myelography lumbar injection code 62284 and imaging guidance codes 72240, 72265 and 72270 for the supervision and interpretation component were identified by the RAW as codes reported together 75 percent or more of the time. Four new codes (62302, 62303, 62304, 62305) were created and will bundle the injection and imaging guidance for myelography procedures. The current injection (62284) and radiologic supervision and interpretation (72240, 72265 and 72270) codes for myelography will be
In addition, the current myelography injection code 62284 was revised to specify it is used for an injection procedure in the lumbar spine. Previously, it was listed as an injection for any part of the spine, except for C1-C2 and posterior fossa.

**Vertebroplasty**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>22510</td>
<td>Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic</td>
</tr>
<tr>
<td>22511</td>
<td>lumbosacral</td>
</tr>
<tr>
<td>+22512</td>
<td>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, 22315, 22325, 22327, when performed at the same level as 22510, 22511, 22512)</td>
</tr>
<tr>
<td>22513</td>
<td>Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic</td>
</tr>
<tr>
<td>22514</td>
<td>lumbar</td>
</tr>
<tr>
<td>+22515</td>
<td>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)</td>
</tr>
</tbody>
</table>

Percutaneous vertebroplasty and vertebral augmentation CPT codes 22520, 22521, 22522, 22523, 22524 and 22525 were identified as being reported together with guidance code 72291, *Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance, 75 percent or more of the time.*

The ACR, as part of a multispecialty society workgroup, used this opportunity to meet the expectation to bundle these codes, and to also create an updated code family that aligns how CPT describes other spinal procedures. New codes for vertebroplasty (22510-22512) and vertebral augmentation (kyphoplasty) (22513-22515), which include imaging guidance, will be created for use in 2015. The current codes 22520, 22521, 22522, 22523, 22524, 22525, 72291 and 72292 will be deleted. The sacroplasty Category III codes 0200T and 0201T will be revised to include imaging guidance and biopsy when performed.

**Transcatheter Placement of Intravascular Stents [37218]**

<table>
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<th>Code</th>
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<tr>
<td>37218</td>
<td>Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation</td>
</tr>
</tbody>
</table>

A multispecialty society request was made to establish a new code (37218) to report the transcatheter placement of an intrathoracic common carotid artery or innominate artery vascular stent.

Editorial revision of the cervical carotid artery stent codes 37215-37216 and 0075T-0076T (see Category III section below) will be made to differentiate these codes from 37218 and to make them consistent with all other endovascular bundled coding. Codes 37215 and 37216 will be revised to specify "open or percutaneous" and to specify "including angioplasty, when performed, and radiological supervision and interpretation."
In addition, codes 37236 and 37237 will be revised to specify these codes do not apply for placement of an intravascular stent in the lower extremity arteries for occlusive disease.

**Cervicocerebral Arteries**

Editorial revision to the introductory notes for the appropriate reporting of codes 36218 and 36228 have been made in the CPT 2015 codebook. Guidance is provided to address coding uncertainties and questions that have arisen since the cervicocerebral artery codes 36221-36228 came into use in 2013.

As noted in the CPT 2015 codebook, code 36218 is to be used in conjunction with 36216, 36217, 36225, 36226. For angiography, coders are directed to code 36222-36228, 75600-75774, and 75792. For angioplasty, coders are referred to 35472 and 35475.

**Arthrocentesis**

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 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting

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

(Do not report 20610, 20611 in conjunction with 27370, 76942)

(If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, 77021)

Three new codes (20604, 20606 and 20611) were proposed to describe ultrasound imaging guidance as an inclusive component of arthrocentesis, aspiration and/or injection of a joint or bursa. Fluoroscopic-guided arthrocentesis will remain component coded. Revisions were made to 20605 and 20610 to denote the procedures are performed without ultrasound guidance.

**Radiation Oncology**

**Isodose Calculation and Planning**

77306 Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)

77307 complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)

(Only 1 teletherapy isodose plan may be reported for a given course of therapy to a specific treatment area)

(Do not report 77306, 77307 in conjunction with 77300)

(77310 has been deleted. To report, see 77306, 77307)

(77315 has been deleted. To report, use 77307)

77316 Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)

(For definition of source, see clinical brachytherapy introductory guidelines)

77317 intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)

77318 complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)

(Do not report 77316, 77317, 77318 in conjunction with 77300)
Teletherapy isodose planning codes 77305-77315 and brachytherapy isodose planning codes 77326-77328, which are frequently reported with the basic radiation dosimetry calculation code 77300, were identified in the codes inherently performed together 75 percent of the time or greater, as the planning codes now universally require performance of dosimetry calculation as an integral part of the procedure.

Five new bundled codes (77306, 77307, 77316, 77317, 77318) will be created to reflect the current process of care for teletherapy and brachytherapy isodose planning. As the new codes now include basic dosimetry calculation(s), code 77300 should not be reported in conjunction with these codes. The current codes 77305-77315 and 77327-77328 will be deleted in 2015.

**Radiation Treatment Delivery**

77385 Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
(To report professional component [PC] of guidance and tracking, use 77387 with modifier 26)
77386 complex
(To report professional component [PC] of guidance and tracking, use 77387 with modifier 26)
(Do not report 77385, 77386 in conjunction with 77371, 77372, 77373)
77387 Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed

Several issues required CPT clarification as clinical practice has evolved. Three new codes (77385, 77386, 77387) will be created to report radiation treatment delivery services, and clarify which codes contain the technical component, professional component or both. The fourteen current codes that describe ultrasound guidance (76950), radiation treatment delivery codes (77403, 77404, 77406, 77408, 77409, 77411, 77413, 77414, 77416, 77418, 77421), and Category III codes (0073T, 0197T) will be deleted.

77401 Radiation treatment delivery, superficial and/or ortho voltage, per day
(Do not report 77401 in conjunction with 77373)
77402 Radiation treatment delivery, ≥1 MeV; simple
(Do not report 77402 in conjunction with 77373)
(77403, 77404, 77406 have been deleted. To report, use 77402)
77407 intermediate
(Do not report 77407 in conjunction with 77373)
(77408, 77409, 77411 have been deleted. To report, use 77407)
77412 complex
(Do not report 77412 in conjunction with 77373)
(77413, 77414, 77416 have been deleted. To report, use 77412)

Revision of the guidelines and editorial revision of the radiation treatment delivery codes 77401, 77402, 77407, 77412 also will be made. Note that the *CPT 2015* code book inadvertently listed the “greater than” (>) symbol instead of the “greater than or equal to” (≥) symbol for codes 77402, 77407, and 77412. The *AMA Errata* web site notes the correction of this error.

**Category III Codes**

- 0348T Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)
- 0349T upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)
- 0350T lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)

Category III codes 0348T, 0349T and 0350T will be established to describe radiologic examination, radiostereometric analysis (RSA) of the spine, upper extremity(ies) and lower extremity(ies).
Although recently listed in the *CPT 2015* code book as new, codes Category III codes 0340T and 0346T were available for use in 2014.

**Revisions**

0075T Transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel +0076T each additional vessel (List separately in addition to code for primary procedure)

0200T Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed

0201T Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed

Category III codes requiring revision included the transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent codes 0075T and 0076T. Reference to intrathoracic was deleted, as intrathoracic is now described by 37218. In addition, the term "open" was added to indicate these codes should be used to report open procedures, as well as percutaneous procedures.

The Category III percutaneous sacral augmentation (sacroplasty) codes 0200T and 0201T descriptors were revised to include imaging guidance and bone biopsy when performed.

**Deletions**

0073T Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session

0197T Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3D positional tracking, gating, 3D surface tracking), each fraction of treatment

Radiation oncology codes 0073T compensator-based beam modulation treatment delivery and 0197T intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy will be deleted as they have been replaced by Category I codes 77385 and 77387 respectively.

The CMS-approved values for codes will not be known until the Medicare Physician Fee Schedule Final Rule is published in the *Federal Register*, typically in November.

Radiology practices are urged to update their CPT reference material yearly, as there are many changes to the guidelines and codes. For a complete listing of code changes, please reference the *CPT 2015* codebook.