The ACR worked either alone or in conjunction with other specialty societies on a number of code proposals for the 2016 code cycle. As in the past, a number of the proposed changes are in response to procedure codes caught in the Relativity Assessment Workgroup (RAW) of the American Medical Association/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) screens to identify possibly misvalued codes.

The following provides a listing of code changes approved for 2016.

**Diagnostic Radiology**

*Laryngography*

**70373** Laryngography, contrast, radiological supervision and interpretation

Code **70373** for laryngography will be deleted, as this service is no longer provided and was replaced by endoscopy and computed tomography.

*Thoracolumbar X-rays of the Spine*

**72080** Radiologic examination, spine; thoracolumbar, 2 views

(For a single view examination of the thoracolumbar junction, use 72020)

**72081** Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view

(For a single view that includes the entire thoracic and lumbar spine, use 72081)

**72082** 2 or 3 views

**72083** 4 or 5 views

**72084** minimum of 6 views
The parenthetical (For a single view examination of the thoracolumbar junction, use 72020) will be added following code 72080, and four new codes added to describe the number of thoracolumbar (TL) views performed vs the types of views. These changes are in line with the other spine code families. Codes 72010 (survey), 72069 (TL, standing), and 72090 (scoliosis) will be deleted.

**Hip X-rays**

73501  Radiologic examination, hip, unilateral, with pelvis when performed; 1 view

73502  2-3 views

73503  minimum of 4 views

73521  Radiologic examination, hips, bilateral, with pelvis when performed; 2 views

73522  3-4 views

73523  minimum of 5 views

The one-view hip code 73500 and one-view pelvis code 72170 were identified as being reported together greater than 75 percent of the time and, therefore, were recommended for bundling. The bilateral hip code 73520 was caught in the high utilization screen and without clear RUC surveys to allow for valuation. There also was much confusion on how to code a hip study when a pelvis was included. Therefore, the ACR recommended the hip code family be sent back to CPT for restructuring to eliminate ambiguity and before being valued by the RUC. The existing stand-alone pelvis code, 72170 will remain, as it is still performed as an individual procedure. Current hip codes 73500, 73510, 73520, 73530, and 73540 will be deleted.

**Femur X-rays**

73551  Radiologic examination, femur; 1 view

73552  minimum 2 views
Code 73550, *Radiologic examination, femur, 2 views*, was caught in the high utilization screen and with no clear RUC survey data to allow valuation. Therefore, the femur code 73550 was referred back to CPT for restructuring to eliminate ambiguity. Two new codes will be created to describe a single-view femur exam and a minimum of two views exam. The current two-view femur exam code 73550 will be deleted.

**Editorial Change of Radiology Descriptors Containing the Word “Film”**

74240, 74241, 74245, 74246, 74247, 74250, 74251, 74340, 77057, 77417

Look for editorial revision to the current radiology code descriptors that use the term *film(s)*. The use of the term *film* is inappropriate as it limits the use of these codes to film technology. Because digital imaging is now typical, but film is still used in some smaller practices and in rural areas, the descriptors will be changed to denote “image(s)” in place of “film(s).” This will allow the appropriate reporting of the codes without limiting their use to either film or digital.

The word "film" in the computer-aided detection codes 77051 (*diagnostic mammography*) and 77052 (*screening mammography*) is correct and appropriate in the context used, and those descriptors will not be revised.

**Fetal MRI**

74712  Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation

74713  each additional gestation (List separately in addition to code for primary procedure)

(Use 74713 in conjunction with 74712)

(Do not report 74712, 74713 in conjunction with 72195, 72196, 72197)

(If only placenta or maternal pelvis is imaged without fetal imaging, see 72195, 72196, 72197)
Two new codes to describe fetal MRI will be established to accurately reflect the resources assigned to fetal MRI, which will allow for the accurate reporting for MRI acquisition and evaluation of the placenta and maternal pelvis. Fetal MRI is unrelated to pelvic MRI except by location.

**Interventional Radiology and Breast Imaging**

**Soft-Tissue Marker Placement**

10035    Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion

10036    each additional lesion (List separately in addition to code for primary procedure)
(Use 10036 in conjunction with 10035)
(Do not report 10035, 10036 in conjunction with 76942, 77002, 77012, 77021)
(To report a second procedure on the same side or contralateral side, use 10036)

Two new soft-tissue marker placement with imaging guidance codes, 10035 and 10036, will be created to describe those procedures not currently described in CPT. If a more specific site descriptor other than soft tissue is applicable (eg, breast), the site-specific code for marker placement at that site should be used.

**Arterial Mechanical Thrombectomy**

37184    Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel

(Do not report 37184 in conjunction with 61645, 76000, 76001, 96374, 99143-99150)

37185    second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)

(Do not report 37185 in conjunction with 76000, 76001, 96375)
Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure) (Do not report 37186 in conjunction with 76000, 76001, 96375) (Do not report 37186 in conjunction with 61645 for treatment of the same vascular territory. See Nervous System Endovascular Therapy)

Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day (For intracranial arterial mechanical thrombectomy and/or infusion for thrombolysis, use 61645)

Codes 37184, 37185, and 37186 will be revised to designate “non-intracranial. The descriptor for code 37211 will be revised to indicate this code should not be reported when arterial thrombolysis is performed in a non-coronary or intracranial artery. Codes 37211-37214 were developed primarily for use in the peripheral vascular system to treat peripheral vascular disease.

Code 37202 will be deleted and coders referred to new codes 61650 and 61651 for intracranial arterial administration of pharmacological agent[s] other than for thrombolysis. Code 75896 also will be deleted. Coders will be referred to 37211-37214 for radiological supervision and interpretation for thrombolysis other than coronary.

Intravascular Ultrasound (IVUS) Bundling

+37252 Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial non-coronary vessel (List separately in addition to code for primary procedure)

+37253 each additional non-coronary vessel (List separately in addition to code for primary procedure)
Two new intravascular ultrasound add-on codes will be created that bundle the surgical and the supervision and interpretation codes. This will allow the acquisition of practice expense data for this procedure, which is now done in the office. The current codes 37250, 37251, 75945, and 75946 will be deleted.

**Percutaneous Biliary Procedure Bundling**

47531 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access

47532 new access (eg, percutaneous transhepatic cholangiogram)

(Do not report 47531, 47532 in conjunction with 47490, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540, 47541 for procedures performed through the same percutaneous access)

(For intraoperative cholangiography, see 74300, 74301)

47533 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; external

47534 internal/external

47535 Conversion of external biliary drainage catheter to internal/external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation

47536 Exchange of biliary drainage catheter (eg. external, internal/external, or conversion of internal/external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation (47536 includes exchange of one catheter. For exchange of additional catheter[s] during the same session, report
47536 with modifier -59 for each additional exchange)  
(Do not report 47536 in conjunction with 47538 for the same access)  

47537 Removal of biliary drainage catheter, percutaneous, requiring  
fluoroscopic guidance (eg, with concurrent indwelling biliary stents),  
including diagnostic cholangiography when performed, imaging  
guidance (eg, fluoroscopy) and all associated radiological supervision  
and interpretation  
(Do not report 47537 in conjunction with 47538 for the same access)  

47538 Placement of stent(s) into a bile duct, percutaneous, including  
diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or  
ultrasound), balloon dilation, catheter exchange or removal when  
performed, and all associated radiological supervision and  
interpretation, each stent; existing access  
(Do not report 47538 with 47536,47537 for the same percutaneous  
access)  

47539 new access, without placement of separate biliary drainage  
catheter  

47540 new access, with placement of separate biliary  
drainage catheter (eg, external or internal/external)  
(Do not report 47538, 47539, 47540 in conjunction with 43277, 47542,  
47555,47556 for the same lesion in the same session)  
(Do not report 47540 in conjunction with 47533-47534 for the same  
percutaneous access)  

47541 Placement of access through the biliary tree and into small bowel to  
assist with an endoscopic biliary procedure (eg, rendezvous  
procedure), percutaneous, including diagnostic cholangiography when  
performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and  
all associated radiological supervision and interpretation; new access  
(Do not report 47541 with 47531-47540)  
(Do not report 47541 when there is existing catheter access)  
(For use of existing access through the biliary tree into small bowel to  
assist with an endoscopic biliary procedure, see 47535, 47536, 47537).  

47542 Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty),  
percutaneous, including imaging guidance (eg, fluoroscopy) and all  
associated radiological supervision and interpretation, each duct (List  
separately in addition to code for primary procedure)  
(Use 47542 in conjunction with 47531-47537, 47541)  
(Do not report 47542 in conjunction with 47538-47540, 43262, 43277, 47555, 47556)
(Do not report 47542 in conjunction with 47544 if a balloon is used for removal of calculi, debris, and/or sludge rather than for dilation)
(For percutaneous balloon dilation of multiple ducts during the same session, report 47542 with a -59 modifier once for all additional ducts dilated)
(For endoscopic balloon dilation, see 43277, 47555, 47556)

47543  Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps and/or needle), including imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)
(Use 47543 in conjunction with 47531-47540)
(Report 47543 once per session)
(For endoscopic brushings, see 43260, 47552)
(For endoscopic biopsy, see 43261, 47553)

47544  Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
(Use 47544 in conjunction with 47531-47540)
(Do not report 47544 if no calculi or debris are found, even if removal device is deployed)
(Do not report 47544 in conjunction with 43264, 47554)
(Do not report 47544 in conjunction with 47531-47543 for removal of incidental sludge and/or debris)
(For endoscopic removal of calculi see 43264, 47554)
(For endoscopic destruction of calculi, use 43265)

Current percutaneous biliary procedure codes 47500, 47505, 47510, 47511, 47525, 47530, 74305, and radiological supervision and interpretation codes 74320, 74327, 75980, and 75982 will be deleted.

New image-guided percutaneous biliary codes, 47531-47541, that bundle percutaneous biliary procedures and imaging guidance will be available for use in 2016.
The percutaneous biliary procedure codes 47500, 47505, 47510, 47511, 47525, 47530, and radiological supervision and interpretation codes 74305, 74320, 74327, 75980, and 75982 were identified as procedures being reported together greater than 75 percent of the time and recommended for bundling. These stand-alone codes are scheduled for deletion in 2016. In addition, code 47630 will be deleted and 47544 used to report percutaneous biliary duct stone extraction.

Percutaneous Image-Guided Sclerotherapy of Fluid Collection

49185  Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed
  (For treatment of multiple lesions in a single day requiring separate access, use modifier 59 for each additional treated lesion)
  (For treatment of multiple interconnected lesions treated through a single access, report 49185 once)
  (For access/drainage with needle, see 10160, 50390)
  (For access/drainage with catheter, see 10030, 49405, 49406, 49407, 50390)
  (For exchange of existing catheter, before or after injection of sclerosant, see 49423, 75984)
  (For sclerotherapy of a lymphatic/vascular malformation, use 37241)
  (For sclerosis of veins or endovenous ablation of incompetent extremity veins, see 36468, 36470, 36471, 36475, 36476, 36478, 36479)
    (For pleurodesis, use 32560)
    (Do not report 49185 in conjunction with 49424, 76080)

Code 49185 will be established to describe percutaneous sclerotherapy of fluid collections. This procedure involves several steps that are not always used in the related codes. Currently, this procedure is reported using an unlisted code most of the time.

Genitourinary (GU) Bundling

50387  Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation
Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological

existing access

(Do not report 50430, 50431 in conjunction with 50432, 50433, 50434, 50435, 50693, 50694, 50695, 74425 for the same renal collecting system and/or associated ureter)

Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation

(Do not report 50432 in conjunction with 50430, 50431, 50433, 50694, 50695, 74425 for the same renal collecting system and/or associated ureter)

(Do not report 50432 in conjunction with 50395 for dilation of the nephrostomy tube tract)

Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access

(Do not report 50433 in conjunction with 50430, 50431, 50432, 50693, 50694, 50695, 74425 for the same renal collecting system and/or associated ureter)

(Do not report 50433 in conjunction with 50395 for dilation of the nephroureteral catheter tract)

(For nephroureteral catheter removal and replacement, use 50387)

Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract

(Do not report 50434 in conjunction with 50430, 50431, 50435, 50684, 50693, 74425 for the same renal collecting system and/or associated ureter)

Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging
guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
(Do not report 50435 in conjunction with 50430, 50431, 50434, 50693, 74425 for the same renal collecting system and/or associated ureter)
(For removal of nephrostomy catheter requiring fluoroscopic guidance, use 50389)

50606 Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

50693 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract

50694 new access, without separate nephrostomy catheter

50695 new access, with separate nephrostomy catheter

(Do not report 50693, 50694, 50695 in conjunction with 50430, 50431, 50432, 50433, 50434, 50435, 50684, 74425 for the same renal collecting system and/or associated ureter)

50705 Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
(Use 50705 in conjunction with 50382, 50384, 50385, 50386, 50387, 50389, 50430, 50431, 50432, 50433, 50434, 50435, 50684, 50688, 50690, 50693, 50694, 50695, 51610)

50706 Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
(List separately in addition to code for primary procedure)
(Use 50706 in conjunction with 50382, 50384, 50385, 50386, 50387, 50389, 50430, 50431, 50432, 50433, 50434, 50435, 50684, 50688, 50690, 50693, 50694, 50695, 51610)
(Do not report 50706 in conjunction with 50553, 50572, 50953, 50972, 52341, 52344, 52345, 74485)
Most of the existing GU interventional codes, 50392, 50393, 50394, 50398, 74425, 74475, 74480, 75984, were captured in the screen for codes reported together greater than 75 percent of the time. Therefore, new codes will be created to bundle genitourinary procedures with all associated radiological supervision and interpretation. In addition to bundling, the code descriptors for injection and aspiration will be revised. Code 50387 will be revised to agree with the guidelines for nephroureteral catheters. Codes 50392, 50393, 50394, 50398, 74475, and 74480 will be deleted.

Add-on codes 50705 and 50706 will be established to allow greater specificity in reporting these services from other urinary services that may be performed.

**Intracranial Endovascular Intervention Bundling**

61645 Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)

(Do not report 61645 in conjunction with 36221, 36222, 36223, 36224, 36225, 36226, 37184, 61630, 61635, 61650, 61651 for the same vascular territory)

(To report venous mechanical thrombectomy and/or thrombolysis, see 37187, 37188, 37212, 37214)

61650 Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory

61651 each additional vascular territory (List separately in addition to code for primary procedure)

(Use 61651 in conjunction with 61650)
Three new codes will be established to describe percutaneous endovascular therapeutic revascularization of cerebral vessels, and prolonged intracranial arterial continuous infusion (61645, 61650, 61651). The neurovascular system is very different from the peripheral vascular system. CNS vascular diseases, while similar in nomenclature to their peripheral vascular counterparts, have different pathophysiology and clinical consequences.

**Nuclear Medicine**

**Gastric emptying study**

78264 Gastric emptying imaging study (eg, solid, liquid, or both);

78265 with small bowel transit

78266 with small bowel and colon transit, multiple days

(Report 78264, 78265, 78266 only once per imaging study)

The gastric emptying code 78264 will be revised to specify that it is an “imaging” study and to provide examples of the types of study performed, i.e., solid, liquid, or both. In addition, two new codes will be added to describe gastric emptying and small bowel transit, and gastric emptying, small bowel transit, and colon transit. The additional imaging required to record small bowel and colon transit requires added instrument time, and significant additional image processing and interpretation skill. Therefore, two new codes were created to accurately capture this work.

**Radiation Oncology**

**Interstitial Radiation Source Application**

77778 Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed
The predominant use of interstitial radiation source application codes 77776, 77777 and 77778 is for permanent seed prostate low-dose rate (LDR) brachytherapy. Therefore, this family of codes will be compressed into one code, 77778, which will incorporate the work of supervision and handling of the sources (77790). Codes 77776 and 77777 will be deleted.

**Superficial Radiation Therapy**

**77767** Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel

**77768** lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions

**77770** Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel

**77771** 2-12 channels

**77772** over 12 channels

(Do not report 77767, 77768, 77770, 77771, 77772 in conjunction with 77300, 0394T, 0395T)

(For non-brachytherapy superficial [eg, ≤200 kV] radiation treatment delivery, use 77401)

**77789** Surface application of radiation low dose rate radionuclide source

(Do not report 77789 in conjunction with 77401, 77767, 77768, 0394T, 0395T)

**0394T** High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed

(Do not report 0394T in conjunction with 77261, 77262, 77263, 77300, 77306, 77307, 77316, 77317, 77318, 77332, 77333, 77334, 77336, 77427, 77431, 77432, 77435, 77469, 77470, 77499, 77761, 77762, 77763, 77767, 77768, 77770, 77771, 77772, 77778, 77789)
(For high dose rate radionuclide surface brachytherapy, see 77767, 77768)
(For non-brachytherapy superficial [eg, ≤200 kV] radiation treatment delivery, use 77401)

**0395T** High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed (Do not report 0395T in conjunction with 77261, 77262, 77263, 77300, 77306, 77307, 77316, 77317, 77318, 77332, 77333, 77334, 77336, 77427, 77431, 77432, 77435, 77469, 77470, 77499, 77761, 77762, 77763, 77767, 77768, 77770, 77771, 77772, 77778, 77789)
(For skin surface application of high dose rate electronic brachytherapy, use 0394T)

Two new codes will be established and three codes revised to report high dose rate (HDR) radionuclide skin surface, interstitial and intracavitary brachytherapy services. Codes 77767 and 77768 will be created to describe HDR radionuclide surface brachytherapy treatments for skin cancer. New codes were needed to accurately describe the work of treating skin cancers, as the work is different than the work of treating other tumors with HDR radionuclide brachytherapy.

Current codes 77785, 77786 and 77787 will be revised and renumbered to 77770, 77771, and 77772 to describe HDR radionuclide brachytherapy for treating tumors other than skin. Codes 787770-77772 also will include the work of basic dosimetry calculation.

In addition, code 77789 will be revised to specify its use for low dose rate radionuclide surface application.

Category III codes 0394T and 0395T will replace code **0182T** in 2016. Code 0182T is currently used to report HDR electronic brachytherapy for all treatment sites. Because there are differences between HDR electronic brachytherapy for surface (skin) treatment and HDR electronic brachytherapy for intracavitary treatment, two new codes will be made available – one to describe surface (skin) treatment, and another to describe all other body sites.

The ACR’s July 24, 2015 [Advocacy in Action eNews](https://www.acr.org/news-and-commentary/advocacy-in-action) posted an impact analysis of the Medicare Physician Fee Schedule 2016 code changes to help practices prepare for the 2016 changes based on the Centers for Medicare and
Medicaid Services Medicare Physician Fee Schedule (MPFS) and Hospital Outpatient Prospective Payment System (HOPPS) proposed rules. 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.

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. See the November/December ACR Radiology Coding Source for links to the Final Rule.

Please reference the AMA’s *CPT 2016* codebook, *CPT Changes: 2016 An Insider’s View, and Clinical Examples in Radiology* for more detailed information on the appropriate use of the new radiology 2016 codes.