2015 CPT Code Changes

The new CPT changes take effect January 1st. Understanding the new codes is crucial to obtaining the proper reimbursement for your services while also staying compliant with current coding and billing requirements. The changes for 2015 address a number of interrelated issues. Clinical practice has evolved and several issues required CPT clarification. CPT 2015 offers most changes in vascular and non-vascular interventional radiology as well as significant changes in breast imagining and radiation therapy.

Changes to Modifier -59:
Modifier 59 is the most widely used modifier. This modifier is associated with considerable abuse and high levels of manual audit activity; leading to reviews, appeals and even civil fraud and abuse cases. This modifier often overrides the edit in the exact circumstance for which CMS created it in the first place. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment.

Four (4) new modifiers have been established to define specific subsets of Modifier 59.

XE: Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
EXAMPLE: The patient receives an outpatient infusion of antibiotics (CPT code 96365) at 8:00 AM, leaves the facility and returns at 8:00 PM for another infusion of the antibiotics. The second line item 96365 would require the -XE modifier.

XS: Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
EXAMPLE: A skin lesion of the arm was destroyed via laser surgery and reported with CPT code 17000 (Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettgement), premalignant lesions (e.g., actinic keratoses); and another lesion is biopsied on the leg and reported with CPT code 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane including simple closure, unless otherwise listed; single lesion). CPT code 11100 would require the modifier - XS.

XP: Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
EXAMPLE: A laparoscopic hernia repair (CPT code 49650) was performed in the morning by surgeon A; later in the day the patient developed acute abdominal pain and a laparoscopic appendectomy (CPT code 44970) was performed by surgeon B. The -XP modifier would be applied to CPT code 44970.

XU: Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service
EXAMPLE: Two separate lesions are present that are within the same code set, and are excised separately - i.e. a 4 cm. lipoma is excised on the upper thigh (CPT code 27337 - excision tumor soft tissue thigh/knee subcutaneous greater than 3 cm) and a separate lipoma excised on the lower leg (CPT code 27327 - excision tumor soft tissue thigh/knee subcutaneous less than 3 cm). The -XU modifier would be applied to code 27327.
Because of the detailed descriptions associated with these modifiers, it should be more evident as to why the provider is overriding the NCCI edit, and these modifiers will allow CMS to identify whether the edit was overridden appropriately. CMS will continue to recognize the -59 modifier, but notes that Current Procedural Terminology (CPT) instructions state that the -59 modifier should not be used when a more descriptive modifier is available.

**Highlights of the 2015 Changes:**

**CHRONIC CARE MANAGEMENT AND TELEHEALTH:**

Beginning in 2015, CMS will pay $42.60 for a "one-per-month, per-patient CCM code." Rather than using its proposed "G" code to report CCM services, the agency changed course in the final rule to allow physicians to utilize CPT code 99490 for CCM reporting purposes. CMS has finally given telehealth providers a glimpse of its plans to expand reimbursement for telehealth services provided to Medicare beneficiaries. This new CPT code can be bundled with the existing CPT code 99091 for collecting and reviewing patient data, which does not require the beneficiary to be present and pays an average monthly fee of $56.92 to the physician. The final rule also includes a provision that would cover remote-patient monitoring of chronic conditions using existing CPT code 99091 (with a monthly unadjusted, non-facility fee of $56.92). This provision will significantly broaden Medicare payments for remote patient monitoring of chronic conditions—while CPT code 99091 has been available for coverage of patient monitoring for many years, CMS traditionally has required (and will continue to require), that 99091 be billed in conjunction with evaluation and management ("E&M") services (CPT codes 99201-99499), the most common of which are office visits. Yet, since the new CPT code 99490 is an E&M code and is intended for coverage of monitoring chronic conditions, the two services can now be combined as chronic care management and remote patient monitoring with a combined monthly fee of approximately $100.00. Notably, the 99490 and 99091 codes are available nationwide, as they are not considered by CMS as rural-only “telehealth” services. CMS also added seven new procedure codes for telehealth services, including annual wellness visits, psychotherapy services, and prolonged services in the office. Coverage under these new codes would begin in 2015.

Historically, Medicare has provided limited coverage for telehealth services, which has included coverage for interactive audio and video telecommunications that provide real-time communications between a practitioner and a Medicare beneficiary while the beneficiary is present at the encounter. Medicare only has covered the provision of telehealth services if the beneficiary is seen: (a) at an approved “originating site” (e.g., physician offices, hospitals, skilled nursing facilities); (b) by an approved provider (e.g., physicians, nurse practitioners, clinical psychologists); and (c) for a small defined set of services, including consultations, office visits, pharmacological management, and individual and group diabetes self-management training services.

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple chronic conditions expected to last at least 12 months, or until death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.
BREAST IMAGING:
The 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. Also, the existing code for breast ultrasound was deleted and two new codes have been introduced for limited and complete ultrasound. Although, limited versus complete has not been defined.

76641 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
76642 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited
77061 Digital breast tomosynthesis; unilateral
77062 Digital breast tomosynthesis; bilateral
77063 Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)

VERTEBRAL FRACTURE ASSESSMENT:
The existing code representing vertebral fracture assessment (VFA) has been deleted and 2 new codes have been introduced for 2015. One code represents VFA done as part of a bone density study and the other is for VFA alone. The deletion of code 77082 and establishment of two new codes to describe DXA and vertebral fracture assessment were requested for 2015.

77085 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment
77086 Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)

NON-VASCULAR INTERVENTIONAL RADIOLOGY:
JOINT PROCEDURES
New codes for joint aspiration and/or injection have been created to include ultrasound guidance. The existing codes were revised to state “not using ultrasound guidance”. However, one thing to keep in mind is that these procedures are sometimes done under fluoroscopic guidance which was not addressed with the new codes.

20604 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting
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
ABLATION THERAPY

The existing code for radiofrequency bone ablation has been updated to include adjacent soft tissue and radiologic guidance. In addition, a new code has been added for cryoablation of bone tumors. A Category III* code has also been created for cryoablation of pulmonary tumors.

20982 Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis), radiofrequency, including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency

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

0340T Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, includes imaging guidance

MYELOGRAPHY

New myelography codes were created which include the supervision and interpretation. The existing code for myelogram injection has been revised, but with the introduction of the new codes, there is some uncertainty on when would be an appropriate time to assign code 62284 as both seem to represent the injection portion of the procedure.

62284 Injection procedure for myelography and/or computed tomography, spinal lumbar (other than C1-C2 and posterior fossa)

62302 Myelography via lumbar injection, including radiological supervision and interpretation; cervical

62303 Myelography via lumbar injection, including radiological supervision and interpretation; thoracic

62304 Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral

62305 Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)

VERTEBROPLASTY/KYPHOPLASTY

The existing codes for vertebroplasty and kyphoplasty have been deleted for 2015 and new codes have been created to include all imaging guidance. Sacroplasty did not yet receive a new code, but the existing Category III* code has been revised to include all imaging guidance.

22510 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
22512 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)

22513 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

22514 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; lumbar

22515 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; each additional thoracic or lumbar vertebral body (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), unilateral injection(s), including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed

VASCULAR INTERVENTIONAL RADIOLOGY:

Existing codes for carotid stent placement have been revised to include angioplasty and radiologic supervision and interpretation. These codes should also be used for open or percutaneous approach, which is a change for 2015. 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.

37215 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

37216 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection

Previously a Category III* code, there is now a CPT code for placement of intrathoracic common carotid or innominate artery stent. This code includes angioplasty and imaging.

37218 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

PACEMAKER AND IMPLANTABLE DEFIBRILLATOR:
Four new codes were developed for subcutaneous implantable defibrillators. These devices differ from transvenous implantable pacing cardioverter-defibrillators in that subcutaneous defibrillators do not provide antitachycardia pacing or chronic pacing. Revisions were made to CPT codes 33215 – 33220, 33223 – 33225, 33240 – 33264, 33243 – 33249 (# - Resequenced) regarding the phrase "pacing cardioverter-defibrillator". The new language is "implantable defibrillator". Review the new introductory language of the CPT book for pacemakers and implantable defibrillators. Examples of new language:

- 2014 – 33243 – Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by thoracotomy
- 2015 – 33243 – Removal of single or dual chamber implantable defibrillator electrode(s); by thoracotomy

33270 Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed

33271 Insertion of subcutaneous implantable defibrillator electrode

33272 Removal of subcutaneous implantable defibrillator electrode

33273 Repositioning of previously implantable defibrillator electrode

**TRANSCATHETER MITRAL VALVE REPAIR:**

New CPT codes 33418 and 33419 are used to report transcatheter mitral valve repair (TMVR). Code 33419 should only be reported once per session. These codes include the work, when performed, of percutaneous access, placing the access sheath, transseptal puncture, advancing the repair device delivery system into position, repositioning the device as needed, and deploying the device(s). Angiography, radiological supervision, and interpretation performed to guide TMVR are included in these codes.

33418 Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis

33419 Additional prosthesis(es) during same session (List separately in addition to code for primary procedure)

**IMPLANTABLE AND WEARABLE CARDIAC DEVICE EVALUATIONS:**

Changes have been added to the introductory language for implantable and wearable device evaluations. These changes were added to replace implantable cardioverter-defibrillator with implantable defibrillator and language to accommodate the two new codes for subcutaneous defibrillator into the coding guidelines. 33418 Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis

93260 Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system
93261 Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator

ADVANCE CARE PLANNING:
These codes are used to report the face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. When using these codes, no active management of the problem(s) is undertaken during the time period reported. The Final Rule states "For CY 2015, we are assigning a PFS status indicator of 'I' (Not valid for Medicare purposes. Medicare uses another code for the reporting and payment of these services.) to CPT codes 99497 and 99498 for CY 2015. However, we will consider whether to pay for CPT codes 99497 and 99498 after we have had the opportunity to go through notice and comment rulemaking."

99497 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)

RADIATION THERAPY:
Radiation therapy codes underwent significant changes for 2015. Teletherapy isodose planning and brachytherapy codes now include the basic dosimetry calculation and IMRT codes now include guidance and tracking. Also radiation treatment delivery codes were deleted in 2015.

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

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

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

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

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

77385 Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple

77386 Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex
Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed

OTHER PROCEDURES:
New Category III* codes have been introduced for radiostereometric analysis.

0348T Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)

0349T Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)

0350T Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)

*Category III codes are temporary codes created for emerging technology, services, and procedures. Use of these Category III codes allow data collection for these services and procedures.

CPT ADDITIONS:
The following codes have been added:

20604 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting

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

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

22510 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral

22512 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)

22513 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

22514 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; lumbar

22515 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; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

37218 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.

52241 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant

52442 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional angioplasty, when performed, and radiological supervision and interpretation

62302 Myelography via lumbar injection, including radiological supervision and interpretation; cervical

62303 Myelography via lumbar injection, including radiological supervision and interpretation; thoracic

62304 Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral

62305 Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)

64486 Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

64487 Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)

64488 Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)

64489 Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)

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

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

77061 Digital breast tomosynthesis; unilateral

77062 Digital breast tomosynthesis; bilateral

77063 Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)

77085 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment

77086 Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)

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

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

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

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

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

77385 Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple

77386 Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex

77387 Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed

90630 Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use

90651 Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use

91200 Liver elastography, mechanically induced shear wave without imaging, with interpretation and report

92145 Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report

93355 Echocardiography, TEE

0340T Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, includes imaging guidance

0348T Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)

0349T Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)

0350T Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)

**CPT DELETIONS:**
The following codes have been deleted:

00452 Anesthesia for procedures on clavicle and scapula; radical surgery

00622 Anesthesia for procedures on thoracic spine and cord; thoracolumbar sympathectomy

00634 Anesthesia for procedures in lumbar region; chemonucleolysis3

22520 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic

22521 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar

22522 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

22523 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic
22524 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar

22525 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

72291 Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance

72292 Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance

74291 Cholecystography, oral contrast; additional or repeat examination or multiple day examination

76645 Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation

76950 Ultrasonic guidance for placement of radiation therapy fields

77082 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment

77305 Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)

77315 Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)

77326 Brachytherapy isodose plan; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)

77327 Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)

77328 Brachytherapy isodose plan; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)

77403 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV

77404 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV

77406 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater

77408 Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV

77409 Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV

77411 Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater

77413 Radiation treatment delivery, 3 or more separate treatment areas, custom blocking,
tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV

77414 Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV

77416 Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater

77418 Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session

77421 Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy

CPT REVISIONS:
The following code descriptions have been revised:

20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes), without ultrasound guidance

20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa), without ultrasound guidance

20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa), without ultrasound guidance

20982 Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis), radiofrequency including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency

37215 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

37216 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection

37236 Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery

37237 Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery

62284 Injection procedure for myelography and/or computed tomography, spinal lumbar (other than C1-C2 and posterior fossa)

77401 Radiation treatment delivery, superficial and/or ortho voltage, per day

77402 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV; 1MeV, simple

77407 Radiation treatment delivery, up to 5 MeV; intermediate

77412 Radiation treatment delivery, up to 5 MeV; complex
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

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