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Radiology
2017 CPT Update
Effective 1/1/2017

Each year the American Medical Association's CPT-4 code manual is revised to delete codes and/or guidelines, and to add or revise codes to reflect current technologies, techniques, and services. As a service to our radiology clients, APS Medical Billing has summarized those changes to facilitate accurate reporting of the affected services as of January 1, 2017.

A number of new radiology CPT codes have been approved for implementation in 2017. One of the big changes is to Mammography coding and Moderate Sedation. There have also been changes to some angioplasty codes.

Below we have outlined the changes made. All new codes are highlighted in red and revised/deleted codes are noted:

Fluoroscopy

Revised Codes for 2017:

+77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)

+77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)

Category III Codes

Category III codes that have been extended:

0159T Computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI (List separately in addition to code for primary procedure)

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Mammography & Computer-Aided Detection

Deleted Codes for 2017:

77051 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)
77052 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)
77055 Mammography; unilateral
77056 Mammography; bilateral
77057 Screening mammography, bilateral (2-view study of each breast)

New Codes for 2017:

77065 Diagnostic mammography including CAD when performed Unilateral
77066 Diagnostic mammography including CAD when performed Bilateral
77067 Screening mammography including CAD when performed Bilateral

*Note: According to CMS, G0202, G0204 and G0206 will still be used in 2017 as the MACs update their fee schedules to accommodate the new CPT codes above in 2018.

Ultrasound

Deleted Code for 2017:

G0389 Ultrasound b-scan and/or real time with image documentation; for abdominal aortic aneurysm (aaa) screening

New Code for 2017:

76706 for AAA Screening Abdominal Aortic Aneurysm

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Moderate Sedation

Deleted Codes for 2017:

99143 Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; younger than 5 years of age, first 30 minutes intra-service time

99144 Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time

99145 Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)

99148 Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; younger than 5 years of age, first 30 minutes intra-service time

99149 Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; age 5 years or older, first 30 minutes intra-service time

99150 Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)

New Codes for 2017:

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

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

+99153 . . . each additional 15 minutes intraservice time (List separately in addition to code for primary service)

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Previously, the bullseye symbol was used to indicate that moderate sedation was included in certain procedures. This included, but was not limited to, revascularization and angioplasty and image guided fluid collection drainage by catheter percutaneous, for examples. This bullseye designation has been removed from all procedures that previously included moderate sedation, so now the sedation will be billed separately in addition to the procedure.

It will be ***very important that the documentation supports the time of the sedation*** so each unit can be applied. For example, if you are doing a revascularization procedure and sedation is provided by the physician performing the procedure for 55 minutes beginning when the first drug is administered until the physician has completed and the skin to skin time ends. The CPT codes that should be reported are 99152 (first 15 minutes) along with add on code 99153x3 for each additional 15 minutes.

Interventional Radiology

Deleted Codes for 2017:

35471 Transluminal balloon angioplasty, percutaneous; renal or visceral artery
35472 Transluminal balloon angioplasty, percutaneous; aortic
35475 Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel
35476 Transluminal balloon angioplasty, percutaneous; venous
36147 Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)
36148 Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)
36870 Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)
75791 Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation

New Codes for 2017:

36901 Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire

venous outflow including the inferior and superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report
This code should only be assigned if no intervention is performed.

36902 Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty

36903 . . . with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment

36904 Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injections(s);

36905 . . . with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty

36906 . . . with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit

+36907 Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)

+36908 Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)

+36909 Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)

Open & Percutaneous Transluminal Angioplasty PTA

Deleted Codes for 2017:

35471 Transluminal balloon angioplasty, percutaneous; renal or visceral artery
35472 Transluminal balloon angioplasty, percutaneous; aortic
35475 Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel
35476 Transluminal balloon angioplasty, percutaneous; venous

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35450 Transluminal balloon angioplasty, open; renal or other visceral artery
35452 Transluminal balloon angioplasty, open; aortic
35458 Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel
35460 Transluminal balloon angioplasty, open; venous
75962 Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation
75964 Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)
75966 Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation
75968 Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)
75978 Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation

New Codes for 2017:

37246 Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery
+37247 . . . each additional artery (List separately in addition to code for primary procedure)
37248 Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein
+37249 . . . each additional vein (List separately in addition to code for primary procedure)
36473 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
+36474 . . . subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

Epidural Injections

Deleted Codes for 2017:

62310 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
62311 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter

placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)

62318 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic

62319 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)

New Codes for 2017:

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

62321 . . . with imaging guidance (ie, fluoroscopy or CT)

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

62323 . . . with imaging guidance (ie, fluoroscopy or CT)

62324 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

62325 . . . with imaging guidance (ie, fluoroscopy or CT)

62326 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance

62327 . . . with imaging guidance (ie, fluoroscopy or CT)

Codes **62324-62327** are to be used only when a catheter is left in place for more than one calendar day.

Prepared by APS Medical Billing and Professional Consulting, Toledo, OH.

The following resources were used in the preparation of this document: the AMA's *Current Procedural Terminology (CPT) 2017, and CPT 2017 Changes-An Insider's View.*