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A Sampling of Coding Changes to Expect from CPT 2015 for Diagnostic Radiology

The AMA's *Current Procedural Terminology (CPT) 2015* has been published and brings many changes to radiology. Each year the CPT manual is updated to add, delete, or revise codes, and/or to modify guidelines where needed to reflect current technologies, techniques, and provision of services. Illustrated below are some of the main changes that will impact coding and billing for diagnostic radiology services, effective January 1, 2015.

Arthrocentesis

Three new codes were created to include ultrasound imaging guidance during arthrocentesis procedures. Guidance provided via fluoroscopy (77002), CT (77012) or MRI (77021) would remain separately-reportable in addition to the existing arthrocentesis CPT codes 20600, 20605, 20610.

- 20604 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, goes); 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
- 20610 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

Breast Tomosynthesis

Three new codes for 2015 describe diagnostic and screening digital breast tomosynthesis procedures as the current mammography codes do not include this additional physician work or practice expense.

- 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)

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Breast Ultrasound

Breast ultrasound code, 76645, has been deleted effective January 1, 2015, and is being replaced with new, individual codes for reporting complete (all four quadrants of the breast and the retroareolar region) and limited (one or more, but not all of the elements listed in code 76641) ultrasounds.

- 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

Dual-Energy X-ray Absorptiometry (DXA)

Because the dual-energy x-ray absorptiometry bone density (77080) and vertebral fracture assessment (77082) studies have been identified as being performed together 75% or more of the time, bundled coding was created for 2015 with the deletion of 77082 and the addition of two new codes.

- 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)

Endoscopic Foreign Body Retrieval

Editorial revisions to the instructional notes following endoscopic foreign body removal codes 43194, 43215, and 43247 were added to direct the reporting of 76000 for fluoroscopic guidance performed with the procedure.

Myelography

Because myelography lumbar injection (62284) and imaging guidance (72240, 72265, and 72270) were identified as being performed together 75% or more of the time, four new codes were developed to reflect the bundled service when performed together. The current individual codes for the injection and the radiologic S&I will remain in place for use when those services are performed by two separate physicians.

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

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

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- 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

Because percutaneous vertebroplasty and vertebral augmentation (22520 – 22525) and guidance (72291) were identified as being performed together 75% or more of the time, bundled coding was accomplished for 2015 with the deletion of the current codes and the creation of six new codes for these combined services. Category III codes 0200T and 0201T (sacroplasty for vertebral augmentation) have also been revised to include 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; 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)

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- 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