2011 CPT® Code Update

[The Health Insurance Portability and Accountability Act [HIPAA] transaction and code set rules require the use of the medical code set that is valid at the time a service is provided. All billing systems should be updated and the new 2011 codes available for use as of January 1, 2011. There is no grace period to implement new code sets.]

Pertinent changes in the Current Procedural Terminology (CPT®) 2011 codebook that will affect radiology practices will be made and will require revision to your computer systems and charge sheets. Look for significant changes to be made in the interventional radiology code section, which include revision to the lower extremity revascularization family of codes. Most of the changes for 2011 are based on the CPT®/Relative Value Scale Update Committee (RUC) Five-Year Review Identification Workgroup request to specialty societies to move forward with code changes to address high frequency code pairs, substantially increased utilization, and site of service anomalies.

Diagnostic Radiology

Computed Tomography (CT), Abdomen and Pelvis

The ACR and other radiology specialty societies were asked to create a combined code set to describe CT abdomen and CT pelvis performed during the same session, as these codes are reported together greater than 75 percent of the time. Therefore, three new codes have been created to describe combined computed tomography (CT) of the abdomen and pelvis studies differentiated by without (74176), with (74177) and without followed by with (74178) contrast. The stand-alone CT abdomen (74150, 74160, 74170) and CT pelvis (72192, 72193, 72194) codes will remain, as there are times a CT abdomen or a CT pelvis will be performed as a stand-alone procedure.

A table is provided in the CPT 2011 codebook to help determine the appropriate code to report a CT abdomen and/or pelvis study.

Deletion of Xeroradiography and Subtraction Codes

Codes for xeroradiography (76150) and subtraction in conjunction with contrast studies (76350) will be deleted in 2011, as these procedures are obsolete and have been replaced by newer technology.

Deletion Cardiac Catheterization Codes

Codes 93555 and 93556, which describe imaging supervision, interpretation and report for an injection procedure(s) during cardiac catheterization, will be deleted in 2011 along with a number of cardiac catheterization codes. New cardiac catheterization codes have been created, which include imaging supervision and interpretation. See the CPT 2011 codebook introductory guidelines for a full description on how to report these new cardiac catheterization procedures.

Guidance and Supervision and Interpretation Code Revisions

Parentheticals have been updated to indicate that it is not appropriate to report the ultrasound guidance code 76942 in conjunction with transforaminal epidural injection codes (64479-64484, 0228T, 0231T, 0232T), paravertebral facet injection codes (64490-64495), or with the hemorrhoidal vascular bundle(s) ligation code (0249T).
The fluoroscopic guidance code 77003 descriptor was revised and “transforaminal epidural” deleted from the descriptor. A new parenthetical was added to note that you should not use 77003 in conjunction with 64479-64484, 64490-64495 as fluoroscopy has been bundled into these codes. An additional parenthetical was added to emphasize that fluoroscopy codes 77001, 77002 and 77003 should not be reported when fluoroscopic guidance is included in the descriptor.

Revisions to the radiological supervision and interpretation code descriptors 75960, 75962 and 75964 also have been made. The revised descriptors will clarify that the coronary, carotid, vertebral, iliac and lower extremity arteries are excluded from 75960 (*Transcatheter introduction of an intravascular stent(s)*), and that the cervical carotid, renal or other visceral arteries, the iliac and lower extremity arteries are excluded from 75962 and 75964 (*Transluminal balloon angioplasty, peripheral artery*).

**Ultrasound**

**Ultrasound Extremity**

The RUC Five-Year Identification Workgroup identified 76880 as having a significant increase in utilization attributable to an increase in a focused anatomic-specific ultrasound exam. The ACR in conjunction with the American Podiatric Medical Association worked to develop a code structure to differentiate the complete examination usually performed by radiologists from the limited exam usually performed by podiatrists. The work involved and the practice expense for a complete diagnostic ultrasound study is different than that of a focused study of a specific anatomic area. Therefore, code 76880, *Ultrasound, extremity, nonvascular, real time with image documentation*, will be deleted in 2011 and replaced by two new codes: 76881 (complete) and 76882 (limited, anatomic-specific). As described in the *CPT 2011* code book, a complete procedure (76881) includes real time scans of a specific joint that includes examination of the muscles, tendons, joint, other soft-tissue structures, and any identifiable abnormality. A limited study (78882) is an examination of the extremity where a specific anatomic structure such as a tendon or muscle is assessed. In addition, the limited code would be used to evaluate a soft-tissue mass that may be present in an extremity where knowledge of its cystic or solid characteristics is needed.

When spectral and color Doppler evaluation of the extremities is performed, use the appropriate code (93925-93926, 93930-93931, 93970 or 93971) in conjunction with 76881 or 76882.

**Noninvasive Vascular Diagnostic Ultrasound**

The noninvasive physiologic studies of the upper or lower extremity arteries, codes 93922-93924, have been revised and the codes revalued in response to a CPT/RUC Five-Year Review Identification workgroup request. The 2011 code descriptors clearly differentiate between a limited study and a complete bilateral study, Additional instruction also is provided on how to appropriately report these codes. See the *CPT 2011* codebook introductory guidelines prior to the Noninvasive Vascular Diagnostic Studies (93875-93990) section for detailed coding guidelines.
Interventional Radiology

Transluminal Angioplasty/Transluminal Atherectomy/Transcatheter Stent Placement

Major changes to the lower extremity revascularization family of codes have been made.

Open (35454, 35456, 35459, 35480-35485) and percutaneous (35470, 35473, 35474, 35490-35495) transluminal angioplasty (PTA) and transluminal atherectomy and associated imaging (75992-75996) codes have been deleted. Stent codes 37205, 37206, 75960, and peripheral artery balloon angioplasty codes 75962, 75964 have been revised.

New Category I CPT codes, 37220-37235, will be used in 2011 to describe PTA, atherectomy with PTA when performed, stent with PTA when performed, and stent with atherectomy and PTA when performed.

The following table illustrates how these procedures should be coded:

**Table 1: Transluminal Angioplasty/Atherectomy**

<table>
<thead>
<tr>
<th>TERRITORY</th>
<th>PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY (PTA)</th>
<th>AHERECTOMY WITH PTA (WHEN PERFORMED)</th>
<th>STENT WITH PTA (WHEN PERFORMED)</th>
<th>STENT WITH AHERECTOMY AND PTA (WHEN PERFORMED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iliac Each Additional Vessel</td>
<td>37220 +37222</td>
<td>37221 +37222 +37223</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Femoral/Popliteal</td>
<td>37224 37225 37226 37227</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tibial/Peroneal Each Additional Vessel</td>
<td>37228 +37232, +37233</td>
<td>37229 +37232, +37233, +37234</td>
<td>37230 +37232, +37233, +37234, +37235</td>
<td></td>
</tr>
</tbody>
</table>

It is important to note that only one primary code may be reported for the initial vessel treated in each vascular territory. As noted in *CPT Changes 2011: An Insider’s View*, codes 37220-37235 are built on a progressive hierarchy with the more intensive services inclusive of the lesser intensive services; therefore, you are to report the code that represents the most intensive service provided. Note that all endovascular revascularization codes include angioplasty when performed.

These lower extremity endovascular procedures, which can be performed through an open surgical exposure and/or percutaneously, include the work of accessing and selectively catheterizing the vessel (36200, 36140, 36245-36248), traversing the lesion, radiological supervision and interpretation directly related to the intervention(s) performed, embolic protection if used, closure of the arteriotomy by any method, and imaging performed to document completion of the intervention in addition to the intervention(s) performed, and moderate
conscious sedation. However, catheterization for a diagnostic lower extremity angiogram may be reported separately if a different arterial puncture site is necessary.

These lower extremity revascularization codes describe transluminal angioplasty, atherectomy, and stent placement. They are divided into three arterial vascular territories: (1) iliac (three vessels - common, internal and external); (2) femoral/popliteal (single vessel); (3) and tibial/peroneal (three vessels - anterior tibial, posterior tibial and peroneal). The CPT 2011 codebook guidelines provide specific instructions on how to report within each of the three territories.

**Important points to note:**

- Report only one primary code for each vascular territory treated per limb. If multiple vascular territories are treated during the same session, it is appropriate to report the primary code for the initial vessel in each vascular territory.
- Add-on codes are used to report additional second or third vessels treated within the same vascular territory, such as in the iliac or tibial/peroneal territory. Since the iliac and tibial/peroneal territories include three vessels, a maximum of two add-on codes may be reported within each territory.
- Add-on codes are used when treatments are performed in different vessels within the same vascular territory, not for distinct lesions in the same vessel.
- The femoral/popliteal territory is considered one vessel; therefore, add-on codes do not apply.
- The common peroneal trunk is considered part of the three vessels in the tibial/peroneal territory and is not treated as a separate, fourth vessel for CPT reporting of lower extremity endovascular revascularization procedures.
- Multiple stent placements in the same vessel are reported once.
- For a bilateral procedure, use modifier 59 if the same territory(ies) is treated (even if mode of therapy is different). For example, use modifier -59 when the right external iliac artery is treated with angioplasty (37220), and the left external iliac artery is treated with angioplasty and stent (37221-59).
- Lesions treated which cross vascular territories should only be coded once.
- Diagnostic angiography performed at a separate session from an interventional procedure is reported separately. Diagnostic angiography supervision and interpretation codes are reportable when the criteria for the appropriate reporting of them at the same time as interventions are satisfied.
- Mechanical thrombectomy and/or thrombolysis, when used, is reported separately.

Please reference the CPT 2011 codebook, the AMA CPT Changes 2011: An Insider’s View, and the AMA/ACR Clinical Examples in Radiology Winter 2011 issue for detailed coding guidelines on these new lower extremity revascularization codes.

**Transcatheter Placement of Intravascular Stents**

Revisions to transcatheter placement of intravascular stent codes 37205-37208 were made to the descriptors to designate that these transcatheter stent placement codes exclude the iliac and lower extremity arteries. This is consistent with the new lower extremity revascularization codes 37220-37235.

The new and revised codes are listed in the following table:
Transcatheter placement stent(s)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous, intravascular</td>
<td>37205, 37206</td>
</tr>
<tr>
<td>Open, intravascular</td>
<td>37207, 37208</td>
</tr>
<tr>
<td>Iliac</td>
<td>37221, 37223</td>
</tr>
<tr>
<td>Femoral/Popliteal</td>
<td>37226, 37227</td>
</tr>
<tr>
<td>Tibial/Peroneal</td>
<td>37230, 37231, 37234, 37235</td>
</tr>
</tbody>
</table>

Endovascular Repair

Editorial revision to the endovascular repair code 34900 and associated imaging code 75954 will be made to designate that this procedure is performed using an ilio-iliac tube endoprosthesis. New Category III codes to describe the endovascular repair of an iliac artery bifurcation (such as for an aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma) using a bifurcated endoprosthesis (0254T) and the radiological supervision and interpretation (0255T) have been created.

Atherectomy Above the Inguinal Ligaments

New Category III codes (0234T-0238T) will be established to describe atherectomy performed percutaneously and/or through an open surgical exposure in arteries above the inguinal ligaments. These codes include the work of performing the atherectomy and the radiological supervision and interpretation of the atherectomy procedure. Unlike the atherectomy codes below the inguinal ligaments (37225, 37227, 37229, 37231, 37233, 37235), codes 0234T-0238T do not include the work of accessing and selectively catheterizing the vessel, traversing the lesion, embolic protection if used, other intervention used to treat the same or other vessels, or closure of the arteriotomy (by any method). Therefore, it is appropriate to report separately the catheterization codes, any diagnostic studies and any other interventions performed during the same session.

Atherectomy Supra-Inguinal Arteries, by any method (eg, directional, rotational, laser)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Category III Code (January 1, 2011 Implementation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transluminal peripheral atherectomy, including radiological supervision and interpretation (performed percutaneously and/or through an open surgical exposure)</td>
<td>0234T</td>
</tr>
<tr>
<td>Renal Artery</td>
<td>0234T</td>
</tr>
<tr>
<td>Visceral artery (except renal), each vessel</td>
<td>0235T</td>
</tr>
<tr>
<td>Abdominal Aorta</td>
<td>0236T</td>
</tr>
<tr>
<td>Brachiocephalic trunk and branches, each vessel</td>
<td>0237T</td>
</tr>
<tr>
<td>Iliac Artery, each vessel</td>
<td>0238T</td>
</tr>
</tbody>
</table>

Cholecystostomy

Cholecystostomy codes 47480 and 47490 will be editorially revised. Code 47480 will be designated as an open procedure, and code 47490 as a percutaneous procedure that bundles in the imaging. The descriptor for 47490 will clearly define what is included, ie, imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation. Therefore, code 75989 will no longer be reported for image guidance in conjunction with 47490.
The global period for a percutaneous cholecystostomy will be reduced from 90 to 0 days, which will allow for the separate reporting of evaluation and management visits in conjunction with 47490.

**Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic**

Fluoroscopic and computed tomographic (CT) guidance will be bundled into the 2011 editorially revised transforaminal epidural anesthetic and/or steroid injection codes 64479, 64480, 64483, 64484, as either fluoroscopic or CT guidance is required to perform these injections.

Note that ultrasound guidance is not included in the descriptor for codes 64479-64484; therefore, if ultrasound-guidance is used in place of fluoroscopic or CT guidance, one of the newly created Category III bundled ultrasound-guided transforaminal epidural injection procedure codes, 0228T-0231T, should be reported as of January 1, 2011. Similar to the fluoroscopy and CT-guided paravertebral facet joint injection codes created in 2010, these codes are reported per level. If multiple injections are performed at a single level on the same side, the code should only be reported once.

<table>
<thead>
<tr>
<th>Transforaminal Epidural Injection of Anesthetic Agent and/or Steroid (includes fluoroscopy or CT imaging guidance)*</th>
<th>Fluoroscopic or CT Guidance</th>
<th>Ultrasound Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical or Thoracic</td>
<td>64479</td>
<td>0228T</td>
</tr>
<tr>
<td>Cervical or Thoracic, each additional level</td>
<td>64480</td>
<td>0229T</td>
</tr>
<tr>
<td>Lumbar or Sacral</td>
<td>64483</td>
<td>0230T</td>
</tr>
<tr>
<td>Lumbar or Sacral, each additional level</td>
<td>64484</td>
<td>0231T</td>
</tr>
</tbody>
</table>

*These codes describe a unilateral procedure. For bilateral procedures, report modifier 50.

The intent of the CPT Editorial Panel is for all modifiers to be appended to the appropriate codes as a one-line entry. To report the unilateral code with modifier 50 appended to the CPT code as a one-line entry on the claim form indicates that the procedure was performed bilaterally. Some third-party payers have requested that providers repeat a code and append modifier 50 to the code on the second line of the claim form. Check with your local payers for their specific coding instructions.

**Intraperitoneal Catheter Revisions**

Code 49418 was created to describe a complete procedure for the percutaneous insertion of a tunneled intraperitoneal (IP) catheter, such as for peritoneal dialysis or management of malignant ascites. As the descriptor notes, included in this code is the imaging guidance, catheter placement, contrast injection when performed, and the radiological supervision and interpretation.

Codes for catheter placement (49419, 49421) will be revised to reflect the current types of catheters used. Terms such as temporary, permanent, drainage and cannula will be deleted as they are no longer performed or relevant, and the term tunneled will be added to recognize the development of a subcutaneous channel. Code 49419 describes a totally implantable subcutaneous port, and code 49421 describes an open insertion of a tunneled IP catheter for dialysis.

Code 49420 will be deleted since it has been replaced by a number of codes since its creation. For percutaneous or open peritoneal drainage, see codes 49020, 49021, 49040, 49041, 49080 and 49081.

For more details on the IP catheter revisions see CPT Changes 2011: An Insider’s View.
Incision and Drainage Soft-Tissue Abscess

The codes for incision of a soft-tissue abscess, currently differentiated by superficial or deep will be revised, as there is overlap with the incision and drainage codes 10060-10160. Code 20000 will be deleted in 2011, and a cross reference will be added to guide the coder to codes 10060, 10061 for cutaneous and subcutaneous incision and drainage. Code 20005 will be revised to specify that it includes drainage, and that it involves the soft tissue below the deep fascia.

Radiation Oncology

Radiation Treatment Management Guidelines

The guidelines provided prior to the radiation treatment management section in the CPT 2011 codebook have been updated. The introductory notes clearly specify that in order to report one of the treatment management codes (77427-77499), a minimum of one examination of the patient for medical evaluation and management must be made (eg, assessment of the patient’s response to treatment, coordination of care and treatment, review of imaging and/or lab test results with documentation).

Placement of Interstitial Devices (eg, Fiducial Markers)

It should be noted that the descriptor for code 55876 will be revised and go back to its original wording to denote that the placement of interstitial device(s) is via a needle, any approach (Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple.

Code 57155 was revised to clarify that a single tandem is inserted into the uterus — not multiple, as suggested by the old terminology “tandems.”

A new code, 57156, was created to describe the insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy.

Category II Codes

The descriptors for Category II codes 3110F, 3111F and 3112F, which describe the Computed Tomography and Magnetic Resonance Imaging Reports measure, have been editorially revised. The CPT Changes 2011 book notes that when 3111F is reported, code 3110F may also be reported to denote compliance. Modifiers 1P, 2P and 3P may not be reported for this measure as there are no exclusions.

Category III Code Changes

New Category III codes to be implemented as of January 1 include the transluminal peripheral atherectomy codes 0234T-0238T, and endovascular repair of iliac artery bifurcation using a bifurcated external and internal iliac artery codes 0254T-0255T (as described above).

For a listing of new Category III codes approved but not included in the CPT 2011 code book, go to the AMA Web site at www.ama-assn.org/ama1/pub/upload/mm/362/cptcat3codes.pdf
Category III codes are used primarily for tracking new procedures and are not referred to the AMA Relative Value Scale Update Committee for valuation. However, they are carrier priced if the service is covered.

Updates are posted biannually (January and July) and are effective six months after posting. This delay provides time for providers/payers to update systems. These codes are maintained until they meet Category I code requirements or they are archived after five years unless a further need is demonstrated to maintain the Category III code status. Click here for more detailed information on CPT® Category I, II and III codes.

Please refer to the CPT 2011 codebook for a complete listing of new and revised CPT® codes for 2011, and the Fall 2010 Clinical Examples in Radiology Bulletin for a crosswalk to the new 2011 radiology codes, as well as the Winter 2011 and future issues for detailed discussions on the reporting of these new codes.

1AMA’s CPT Changes 2011: An Insider’s View. CPT 2011, p.373.

2AMA CPT Changes 2011: An Insider’s View,