

New CPT Codes for 2017

A preview of the changes ahead for interventional CPT coding effective January 2017.

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It's time for my annual column on new codes being introduced for the upcoming year. Several changes will affect practices in 2017, and this column addresses many of them. There is also a new set of codes for dialysis access interventions that will not be addressed in this column. If your practice performs those services, you will want to become familiar with that new code set in addition to the codes discussed in this article.

MODERATE SEDATION

There are important changes to reporting for moderate sedation (MS) services. Beginning January 1, 2017, MS is no longer bundled into any interventional service and may be separately reported when performed and documented. This is particularly important because for services that previously included MS, value has been deducted from the relative value units assigned to each code to reflect that MS is no longer part of that service. If MS is now not separately reported, that value will be lost. This is a small value for work relative value units for each case, but it may add up significantly over the course of a year. In addition, accurate reporting will likely be very important for practice expense value if MS is being provided in a nonfacility setting.

The previous codes for MS will be retired, and there will be six new codes for MS. In addition, the definitions and rules for reporting MS have been modified. The Centers for Medicare & Medicaid Services has historically not paid for MS separately when it is provided by the physician/qualified health care professional who is also performing the procedure that the MS is supporting, in large part due to overlapping time with both services provided by the same person at the same time. It has been reasoned that paying for both would be "double dipping" or paying for two things at once when a single person can only be doing one thing at a

time. However, as a bundled service, payment for MS was sometimes included when MS was not provided. In some areas of medicine, services have evolved, and MS may no longer be part of the most typical service described by that code. For instance, gastrointestinal endoscopy is usually performed with an anesthesiologist to provide deeper sedation, and MS is given in only a small number of gastrointestinal endoscopy procedures. It was therefore determined that MS would be unbundled. CPT has tried to clarify the additional work and service of MS, even when given by the same provider.

Through discussions in the CPT Workgroup for Moderate Sedation, coding questions posed to me, and discussions of MS in other venues during my career, it is clear to me that there is significant variance in how MS is performed across practices. There is also significant variation in local institutional requirements for reporting MS. In order to be paid appropriately for the service you are providing, it will be very helpful for each provider to understand how your institution and billers define MS and potentially to give input to be sure those definitions include MS as provided in the interventional suite.

MS is defined in CPT, and the MS codes are constructed using this definition. It is intended that reporting of MS for billing should be done using the CPT definitions. Moderate (conscious) sedation is defined in CPT as a drug-induced depression of consciousness. During MS, the patient maintains the ability to purposefully respond to verbal commands (either alone or with light tactile stimulation). The patient is able to maintain cardiovascular and airway function without support, and spontaneous ventilation is adequate for the patient. CPT also specifies that MS is different than the administration of medications for pain control, minimal sedation (anxiolysis), or deeper sedation requiring monitored anesthesia care. The new MS

codes should not be reported for services that do not meet the definition of MS. CPT does not specify the drugs or doses required for reporting MS.

Many institutions have local definitions for MS, including specifics on drugs, dosages, or number of drugs used. Therefore, it may be helpful to discuss the MS changes with your coders prior to reporting the new codes. Educating your coders on how MS is provided and understanding their needs for documentation to support the service you are providing should lead to more successful payments for services. For instance, some practices use an opioid alone for MS, but for compliance purposes, because CPT defines that pain medication given for pain control is not MS, billers may determine that they cannot bill MS when an opioid alone is given. Bidirectional communication and education between providers and billers can help ensure that the correct codes are reported.

MS reporting remains tied to intraservice time of service with the new codes, but CPT has uncoupled the time of MS from the time of the procedure. Previously, MS reporting was tied to intraprocedure time and began with skin incision or vessel puncture. In 2017, this reporting changes so that the reporting time for MS begins with the first dose of sedative medication. The reporting physician must actually order the drug(s) and dosage(s) used throughout the MS and must be face to face with the patient from the time the first dose is given until the end of the MS service. If face-to-face time ends, the time for MS ends, and any additional face-to-face time required later, even if related to MS, is considered postservice work and is not counted as time on which reporting is based.

MS is typically started prior to skin incision, requiring time for the drugs to take effect before the procedure starts, so MS time typically begins prior to procedure start time. However, this is not always the case. For instance, if it is anticipated that MS will not be needed for a procedure and the procedure is started without MS, but the patient requires MS at some later point during the case, the intraservice time used for the purposes of reporting MS is determined from the time of the first dose of MS drugs, not the time that the procedure started.

It is also intended that MS is reported only when the physician/qualified health care professional is actually ordering the drugs and is present during the entire case. It is not appropriate to count time when the physician is not present as part of intraservice time for MS. MS drugs given as a standing order prior to the

physician's arrival in the interventional suite would not be reported as MS intraservice time provided by that physician because he or she was not face to face with the patient.

The intraservice time for MS ends when the physician is no longer required to be face to face with the patient for MS. This time is not determined by physician face-to-face time specifically. In general, this time will be at the completion of the procedure. However, it may be longer, such as when the groin hold is very painful or the patient is unable to cooperate, and MS is required to safely gain hemostasis—but only if the physician remains face to face with the patient.

Intraservice time for MS may also be shorter; for instance, if MS is needed for an early part of a procedure, but a second, lesser procedure does not require MS. The time reported for MS ends when the patient no longer requires MS and is no longer maintained at a level of depressed consciousness. Face-to-face time is required for reporting but is not the sole determinant for reporting MS codes. Staying in the procedure room to chart and make phone calls after the procedure is completed may prolong "face-to-face time" but does not count as MS time if the sedation state of the patient no longer requires that the physician remain with him or her.

The time basis for reporting has changed, with the base code now reported for the first 15 minutes of intraservice time for MS (compared to 30 min previously), in part to account for short-acting drugs used to support very short cases. In order to report MS, the minimum intraservice time is 10 minutes. For any MS intraservice time shorter than 10 minutes, MS is not separately reported. The add-on codes for MS describe additional 15-minute increments of intraservice time. At least half of this time increment is required (> 7.5 min) in order to report an additional increment (ie, a minimum of 23 min of MS time is required: 15 min for the base code plus more than half of the 15-min additional increment). A chart is included in CPT to aid in determining which code(s) to report.

If a single provider is both performing the procedure and providing MS, they must be directly supervising a trained independent observer, who is present throughout the MS and providing constant monitoring of the patient during the MS.

The new codes are divided into two groups: (1) sedation provided by the same provider who is performing the procedure (99151, 99152, 99153), and (2) sedation provided by a separate provider other

than the one performing the procedure (99155, 99156, 99157). Each of these groups is subdivided by age, with separate codes for patients aged younger than 5 years (99151, 99155) versus patients aged 5 years and older (99152, 99156). Each of the two main groups has one add-on code for each additional 15-minute increment of service (99153, 99157), which is used for patients of any age.

- 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 physiologic status; initial 15 minutes of intraservice time, patient aged younger than 5 years
- 99152 initial 15 minutes of intraservice time, patient aged 5 years or older
- +●99153 each additional 15 minutes of intraservice time (list separately in addition to code for primary service)
- 99155 Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient aged younger than 5 years
- 99156 initial 15 minutes of intraservice time, patient aged 5 years or older
- +●99157 each additional 15 minutes of intraservice time

MECHANOCHEMICAL ABLATION OF INCOMPETENT EXTREMITY VEINS

Two new codes will be available in January 2017 to report a newer type of venous ablation for incompetent extremity veins, mechanochemical ablation. These codes describe a method of treating veins that uses dual therapy that includes mechanical plus chemical means to ablate the vein. The mechanical portion is performed using a device that is inserted into the vein and used to disrupt or injure the venous intima along the entire treated segment, making the vein more thrombogenic and causing venous spasm. The chemical portion of the procedure includes instillation of a drug (typically a sclerosant) into the vein, which is

distributed throughout the length of the treated vein to promote thrombosis and closure. Both aspects of this therapy must be performed to use the mechanochemical ablation codes.

- 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

These codes are structured similarly to existing codes for endovenous ablation therapy using radiofrequency (36475, 36476) and laser ablation (36478, 36479). All of these codes (36473–36479) include any anesthetic, all catheterizations of the treated veins, all ultrasound and/or other imaging for the entire procedure (including vein localization, guidance of the therapy, and follow-up imaging to document completion), therapy delivered to the vein, closure of the puncture site, and application of compression stockings when appropriate. The supplies and equipment used for these services are included (not separately billed) when performed in an office setting.

For mechanochemical ablation, local anesthesia at the puncture site is typical (compared to tumescent anesthesia used for radiofrequency and laser ablation therapies).

Codes 36473 and 36474 are each reported a maximum of once per extremity. The base code 36473 is reported for the initial vein treated. If a second vein in the same extremity is treated in the same setting and this is performed from a separate puncture site, the add-on code 36474 is also reported. This add-on code (36474) is reported only once per extremity, regardless of how many additional veins are treated or how many additional puncture sites are required.

CPT uses the same structure for coding radiofrequency and laser endovenous ablation therapy services. The coding descriptors for radiofrequency (36475, 36476) and for laser ablation (36478, 36479) were edited for CPT 2017 to help clarify that the add-on codes for radiofrequency and laser ablation are only reported once per extremity per session, regardless of how many additional veins are treated. Although the descriptors for the add-on codes 36476 and 36479 were edited, the edits were made to clarify the existing use of the codes and do not change the original intent of the codes.

Codes 36473 and 36474 do not describe injection of a sclerosant into a vein through a needle or through a catheter followed by external compression of the vein. Sclerosant injected into a vein via a catheter without endovascular mechanical venous disruption is reported using code 37799. The mechanical and chemical portions of the procedure are both required to report 36473 and 36474. These new codes also do not describe treatment of incompetent veins by injection of a chemical adhesive, which is reported using 37799.

TRANSLUMINAL BALLOON ANGIOPLASTY

Four new codes for transluminal balloon angioplasty will become effective January 1, 2017. Several existing codes for angioplasty will be deleted at the same time, including existing codes for open and percutaneous aortic, brachiocephalic artery, and venous angioplasty (35450, 35452, 35458, 35460, 35471, 35472, 35475, 35476, 75962, 75964, 75966, 75968, 75978). The new codes bundle the surgical portion of the angioplasty with the radiological supervision and interpretation portion of the service. The new codes do not distinguish between services performed via open exposure or percutaneous access. These four new codes include all work and imaging required to complete the angioplasty. The new codes do not include catheterization of the vessel, which is separately reported.

- 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 each additional artery (list separately in addition to code for primary procedure)
- +●37247
- 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)

These codes report services provided in arteries and veins where more specific CPT codes are not available. The descriptors specify that 37246 and 37247 are not to be used for angioplasty of intracranial, pulmo-

nary, coronary, or dialysis circuit arteries or for lower extremity arteries for occlusive disease because there are CPT codes that specifically describe those services. The descriptors for 37248 and 37249 specify that these codes are not used for dialysis circuit venous angioplasty because there are CPT codes that specifically describe these services.

These codes are reported per vessel treated (not per lesion treated). The first vessel treated with angioplasty is reported with the base code (37246 for artery, 37248 for vein), and each additional vessel treated with angioplasty is reported with an add-on code (37247 for each additional artery, 37249 for each additional vein). If a stent is placed in the same vessel that is treated with angioplasty in the same setting, only the stent code is reported. This is true even if one or more lesions in the vessel are treated with angioplasty alone and a separate, distinct lesion is treated with a stent (with or without angioplasty in addition to stenting of that lesion). If a lesion extends across two vessels but is treated with a single therapy, a single code is reported for this angioplasty procedure. ■

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you would like



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Disclosures: None.