2017 CPT Coding Update

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The 2017 update to the CPT code set brings fewer new codes than in previous years but more guideline changes and clarifications, as well as revisions in code description. One Appendix is deleted and a new one is created. There are a total of 149 new CPT codes, 498 revised codes, and 81 deleted codes.

There are no new Evaluation and Management codes for 2017, and only one Evaluation and Management code is deleted. Medicare coverage for chronic care management and prolonged services has increased. Medicare has covered only code 99490 for 20 minutes of clinical staff time spent managing the patient's chronic conditions. For 2017, two CPT codes existing since 2013 will be covered by Medicare. Code 99487 is for 60 minutes of clinical staff time, and 99489 is for each additional 30 minutes of time. Both of these codes require documentation of a substantial revision in the patient's plan of care. The Centers for Medicare and Medicaid Services (CMS) has also created a new G-code, G0506, as an add-on when the patient is enrolled in chronic care management at a face-to-face encounter. Other G-codes have been added for Behavioral Health Integration, G0507, and Psychiatric Collaborative Care, G0502, G0503, G0504. A new code was also created for Care Planning for Patient with Cognitive Impairment, G0505. This code is expected to be a CPT code in 2018. Medicare will also now pay for existing codes 99358 and +99359 for prolonged services before and/or after direct patient care.

The CPT Surgery section sees 51 new codes, 360 revised codes, and 29 deleted codes with the update. Recognizing that existing code +22851 did not adequately describe the levels of complexity in insertion of biomechanical devices with spine surgery, three new codes were created:

- +22853 when inserted to intervertebral disc space in conjunction with interbody arthodesis
- +22854 when attached to vertebral corpectomy(ies), in conjunction with interbody arthodesis
- +22859 when performed without interbody arthodesis

There are also new codes in the Spine Surgery section for insertion of stabilization devices when there is no fixation. Codes 22867 and +22868 are used when there is open decompression, while codes 22869 and +22870 are used when there is no decompression.

New codes for treatment of pelvic ring fracture account for differences in complexity based on whether the fracture is anterior or posterior and whether manipulation is required. Code 27197 is for closed treatment of a posterior pelvic ring fracture without manipulation, code 27198 is used if manipulation is required under greater than local anesthesia. For closed treatment of anterior fracture, the new guidance is to use the appropriate Evaluation and Management service.

Bunionectomy codes have been updated to remove legacy names from code descriptions and to delete codes that describe outdated methods. Two new codes have been created:

- 28291 for hallux valgus correction with cheilectomy with implant; 28289 is specified to be without implant
- #28295 is for hallux valgus correction with sesamoidectomy

Laryngoscopy code changes include several new codes as well as guidelines for laryngoscopy with sinus endoscopy and clarification of unilateral versus bilateral codes. New code 31572 is for laryngoscopy with ablation of destruction of lesion(s); code 31573 is for laryngoscopy with therapeutic injections; code 31574 is for laryngoscopy with injection(s) for augmentation. New laryngoplasty codes to treat laryngeal stenosis, 31551-31554, are differentiated by the age of the patient and whether a graft or stent is placed. CPT code 31591 will be for unilateral medialization laryngoplasty, and code 31592 is to be used for cricotracheal resection.

Cardiovascular Surgery coding changes include a new code 33340 for percutaneous transcatheter closure of the left atrial appendage. As with most procedures performed under fluoroscopic guidance, this code includes radiological supervision and

interpretation as well as transseptal puncture, catheter placement(s), left atrial angiography, and left atrial appendage angiography. Aortic valve repair codes will now distinguish between open and closed, simple and complex. New codes 33390 and 33391 are for open procedures. Existing codes 33405, 33406, and 33410 are likewise now specified to be for open procedures.

Two new codes have been established for Mechanochemical Ablation (MOCA). MOCA involves two ablation modalities for incompetent veins—mechanically damaging the intima of the vein followed by injecting sclerosant. Code 36473 will be used for the first vein treated in an extremity, code +36474 for subsequent vein(s) in the same extremity, through separate access sites. These codes include all imaging guidance and monitoring.

New coding concepts are established for hemodialysis access treatments, now labeled as Dialysis Circuit Maintenance. New definitions for coding purposes describe a peripheral segment and a central segment. Codes are hierarchical in nature and begin with 36901 for diagnostic angiography of the circuit. Additional codes are for treatment of a stenosis by angioplasty and/or stent and for mechanical thrombectomy, differentiated by location in the peripheral segment or the central segment.

Epidural/Subarachnoid Injections codes 62320-62327 are established to distinguish not only the level of the spine injected but also whether the procedure was performed under guidance. Ultrasound guidance is not applicable for these procedures, and procedures performed under ultrasound guidance would be coded as without guidance. Additional coding clarifications are that the code is based on the level at which the catheter enters the body and that infusions of less than 24 hours are to be coded as injections. CPT code 62380 is also established for endoscopic decompression of the spinal cord and nerve root(s).

Radiology Section changes include establishment of code 76706 for Abdominal Aorta Ultrasound Screening, replacing HCPCS code G0389, and new mammography codes. The new mammography codes, 77065-77067, bundle computer-aided detection into the mammography but otherwise mirror previous code structure and definition. Medicare will not cover new codes for 2017 and has issued corresponding G-codes G0202, G0204, and G0206. Medicare is expected to cover the CPT codes in 2018.

New laboratory codes have been established for presumptive drug testing, mirroring existing HCPCS codes. New guidelines and new codes have been established for Molecular Pathology. A new section of CPT for Proprietary Laboratory Analyses is established. This section contains alpha-numeric codes for sole-source tests or sole-source kits. These codes will also be published quarterly on the American Medical Association's website.

Vaccine codes have been revised to remove age indications and replace them with dosage amounts. One new vaccine code is established for quadrivalent influenza vaccine. CPT codes 92235 and 92240 are specified to be unilateral or bilateral, and new code 92242 is established for use when both fluorescein angiography (92235) and indocyanine-green angiography (92240) are performed on the same day. New codes 93590, 93591, and 93592 are for percutaneous transcatheter closure of paravalvular leak. Health and Behavior Assessment code 99420 is replaced by 96160 for patient-focused health risk assessment instrument and 96161 for caregiver-focused health risk assessment instrument. New oncology code 96377 will be used for preparation and application of on-body injector for subcutaneous injection for patients to receive injection at home 24 hours after chemotherapy administration.

New codes have been established for Physical Therapy, Occupational Therapy, and Athletic Training evaluations to differentiate in levels of work based on the patient's medical history and clinical presentation, severity of the patient's condition, and complexity of the provider's medical decision making.

Moderate sedation will no longer be bundled with any surgery code, resulting in the bull's-eye symbol being removed from 180 codes. Appendix G has also been removed. New codes for moderate sedation are differentiated by whether the service is performed by the same physician or another physician and whether the patient is older or younger than five years. Codes 99155-99157 for services by another physician cannot be billed in the non-facility setting. CMS has established G0500 for moderate sedation by same practitioner for GI services.

Category III codes represent new technology. These services may not necessarily be approved by the Food and Drug Administration and may not be reimbursed by many payers. Codes in this section are either moved to Category I or are removed after five years. In 2017, codes for esophageal sphincter augmentation and for laparoscopic ablation of uterine fibroids are converted from Category III codes to Category I codes. New Category III codes include codes for cardiac contractility modulation system, destruction of neurofibromas, transurethral waterjet ablation of the prostate, tactile breast imaging, phrenic nerve stimulation system, and permanent aortic counterpulsation ventricular assistance device.

As coverage of telehealth services continues to increase, CPT establishes a new modifier, 95, to be appended to existing CPT codes. Appendix P has also been established and includes codes that show evidence of being covered by any payer. A new place of service code has also been established for Telehealth, 02.

This article is an overview. Before billing these new codes, providers should review the specific coding, documentation, and reimbursement requirements for each.

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