Coding Updates for 2021

An overview of updates to endovascular and interventional CPT coding for your practice.

By Katharine L. Krol, MD, FSIR, FACR, RCCIR

This article describes coding changes for endovascular and interventional procedures that took effect on January 1, 2021.

KEY

- ▲ Designates an existing CPT code with new revisions in 2021
- ● Designates a new CPT code in 2021
- \+ Designates an add-on code that must be reported with the appropriate base code

There are relatively few changes in endovascular and interventional procedural coding for 2021. The major CPT change for 2021 is evaluation and management (E/M) coding for office or outpatient visits. The codes have been revised to more closely reflect how providers provide E/M services and to simplify coding for these services, reducing administrative burden and paperwork for providers. As value has been shifted to E/M services, values for procedural services are expected to decrease to maintain the Centers for Medicare & Medicaid's (CMS's) required budget neutrality. If you are providing E/M services, it is important to understand the new codes and report them for the services provided. This article reviews coding changes that took effect on January 1, 2021, and briefly describes the main changes to the E/M codes. The reader is referred to the American Medical Association (AMA) website for additional information (ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf), as well as the CPT 2021 Professional Code Book.

OFFICE OR OTHER OUTPATIENT VISITS

Code 99201 has been deleted, and codes 99202-5 (new patient) and 99211-5 (established patient) have been modified. The criteria used to determine the level of service provided are different, and the level of service is now determined by either: (1) the level of the medical decision-making (MDM) as defined for each service or (2) the total time for E/M services performed on the date of the encounter.

Bullets are no longer used to determine the level of service. The evaluation and documentation of the elements of the history and physical examination are left to the discretion of the provider, requiring pertinent elements to the specific patient but not encouraging or adding credit to a service for collecting data on multiple bullet points that are not pertinent to the patient or their presenting problem. The use of time as the determining factor for code choice for office and outpatient visits has been modified significantly in 2021.

Different E/M codes count time differently, so it is necessary to understand the rules for each type of E/M service. The method for calculating time for this set of codes has changed in 2021. For the revised office visit codes, time is now counted by total time spent on the date of the encounter. This includes both non–face-to-face time as well as face-to-face time spent with the patient/family by the physician or other qualified health professional but does not include time spent by clinical staff such as a nurse or medical assistant. For example, time spent in preparing for the visit (eg, review of chart, review of tests), time spent in the visit, and time spent after the visit to arrange or coordinate care and document the visit all are counted. Prior to 2021, only time spent directly face-to-face with a patient/family was counted as time included in the codes reported for outpatient visits.

Code 99211 is an exception and is not reported using either time or MDM as the determining factor. This code describes a minimal care visit with an established patient, requiring low-level care that may not require a physician or qualified health care professional and is reported when the service does not meet the requirements for a higher-level service.

New Patient Office or Other Outpatient Visits

▲99202 Office or other outpatient visit for the E/M of a new patient, which requires a medically appropriate history and/or examination and straightforward MDM. When using time for code selection, 15 to 29 minutes of total time is spent on the date of the encounter

▲99203 Office or other outpatient visit for the E/M of a new patient, which requires a medically appropriate history and/or examination and low level of MDM. When using time for code selection, 30 to 44 minutes of total time is spent on the date of the encounter

▲99204 Office or other outpatient visit for the E/M of a new patient, which requires a medically appropriate history and/or examination and moderate level of MDM. When using time for code selection, 45 to 59 minutes of total time is spent on the date of the encounter

▲99205 Office or other outpatient visit for the E/M of a new patient, which requires a medically appropriate history and/or examination and high level of MDM. When using time for code selection, 60 to 74 minutes of total time is spent on the date of the encounter. (For services ≥ 75 min, see Prolonged Services 99417)

Established Patient Office or Other Outpatient Visits

▲99211 Office or other outpatient visit for the E/M of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal

▲99212 Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and straightforward MDM. When using time for code selection, 10 to 19 minutes of total time is spent on the date of the encounter

▲99213 Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and low level of MDM. When using time for code selection, 20 to 29 minutes of total time is spent on the date of the encounter

▲99214 Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and moderate level of MDM. When using time for code selection, 30 to 39 minutes of total time is spent on the date of the encounter

▲99215 Office or other outpatient visit for the E/M of an established patient, which requires a medically appropriate history and/or examination and high level of MDM. When using time for code selection, 40 to 54 minutes of total time is spent on the date of the encounter. (For services ≥ 55 min, see Prolonged Services 99417)

Prolonged E/M Services

CMS did not accept the CPT definitions for prolonged E/M services and issued different guidance in the 2021 final rule. Coding for CMS may be different than other carriers, and it is important to check with individual carriers to understand how they are accepting billing for prolonged office/outpatient E/M services. Table 1 shows the prolonged office outpatient E/M codes for CPT versus CMS.

CPT definitions. These definitions are different than CMS definitions, which are outlined in the subsequent section. For professional time spent on the same date as an office or other outpatient visit that exceeds the time included in the highest level codes mentioned previously (99205, 99215), a new CPT code was added in 2021. Code 99417 may be reported for each additional 15 minutes of total time spent on a patient visit by the professional on the same date. The time spent must exceed 15 minutes more than the minimum time designated in the code (ie, 60 min + ≥ 15 min [≥ 75 min] for code 99205, 40 min + ≥ 15 min [≥ 55 min] for code 99215). Code 99417 may be reported for each additional 15 minutes of total time spent on a patient visit by the professional on the same date. To report 99417, a full 15 minutes of additional time must be spent (ie, if 14 minutes of additional time is spent, 99417 is not reported). Code 99417 may only be reported when the base service (99205 or 99215) is reported using time spent (rather than on MDM criteria).

●+99417 Prolonged office or other outpatient E/M service(s) beyond the minimum required time of the primary procedure, which has been selected using total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time

TABLE 1. PROLONGED OFFICE OUTPATIENT E/M CODES FOR CPT AND CMS					
CPT			**CMS**		
Description	**Duration**	**Code(s)**	**Description**	**Duration**	**Code(s)**
Office E/M, new patient	60-74 min	99205	Office E/M, new patient	60-74 min	99205
	75-89 min	99205, 99417		75-88 min	99205
	90-104 min	99205, 99417, 99417		89-103 min	99205, G2212
	≥ 105 min	99205, 99417 (X 3) (add 99417 for each additional 15 min)		104-118 min	99205, G2212 (add G2212 for each additional 15 min)
Office E/M, established patient	40-54 min	99215	Office E/M, established patient	40-54 min	99215
	55-69 min	99215, 99417		55-68 min	99215
	70-84 min	99215, 99417, 99417		69-83 min	99215, G2212
	≥ 85 min	99215, 99417 (X 3) (add 99417 for each additional 15 min)		84-98 min	99215, G2212 (add G2212 for each additional 15 min)

Abbreviations: CMS, Centers for Medicare & Medicaid; CPT, Current Procedural Terminology; E/M, evaluation and management.

CMS definitions. These are different than the CPT definitions for 99417. CMS disagreed with the CPT definition that prolonged services may be reported when total spent caring for a patient on a single day in an office or other outpatient E/M service exceeds the ***minimum*** required time for the base code by 15 minutes. They have defined prolonged office or other outpatient E/M services as service that exceeds the ***maximum*** time included in the base code by 15 minutes. Because this definition is different than CPT code 99417, CMS created a G code (G2212) that is to be used to report prolonged services in CMS patients. G2212 is reported when services for a new patient is ≥ 89 minutes (74 + 15 min) and for an established patient is ≥ 69 minutes (54 + 15 min).

+G2212 Prolonged office or other outpatient E/M service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact. (Do not report G2212 for any time unit < 15 min)

Additional instructions have been added in CPT for coding for all prolonged services. The codes for prolonged professional services with direct patient contact in the outpatient setting (99354, 99355) and in the inpatient setting (99356, 99357) have additional instructions guiding the use of these codes. Additional instruction have also been added to guide the use of codes for prolonged professional services without direct patient contact (99358, 99359). Codes 99415 and 99416 may be reported for prolonged clinical staff time spent with a patient during an E/M office or outpatient visit. Please refer to the 2021 CPT Manual for additional instructions for using these codes.

PERCUTANEOUS LUNG/MEDIASTINUM BIOPSY

A new code has replaced the previous percutaneous lung biopsy code. 32405 has been deleted and 32408 has been added. The new code is specific for core needle biopsy and bundles any and all imaging guidance used to perform the core needle biopsy. Fine needle aspiration (FNA) is not included in code 32408 and may be reported separately.

●32408 Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed

The code includes the service of percutaneous core needle biopsy of a single lung or mediastinal lesion, regardless of the number of passes or cores or the number of areas sampled within a single tumor and includes fluoroscopic, CT, magnetic resonance, and/or ultrasound guidance. Codes 76942, 77002, 77012, and 77021 may not be reported in conjunction with 32408 for biopsy of a single lung lesion, even if multiple guidance modalities are used.

There are complexities to understand about reporting core needle biopsies if multiple lesions (in the lung or in the lung plus other organs) are biopsied at the same session or if both a core biopsy and FNA biopsy are performed of the same or different lesions.

TABLE 2. CASE EXAMPLES OF PERCUTANEOUS LUNG/MEDIASTINUM BIOPSY AND THEIR CORRESPONDING CODES

Case Example	Code(s)
CNB of RLL lung lesion using fluoroscopic guidance	32408
CNB of RLL lung lesion using CT guidance	32408
CNB of RLL lung lesion using CT and fluoroscopic guidance	32408
CNB of RLL lung lesion with FNA biopsy of the same lesion using CT guidance performed through the same guiding needle	32408, 10009-52
CNB of RLL lung lesion with FNA biopsy of the same lesion using CT guidance but performed through separate punctures rather than through the same guiding needle	32408, 10009-52
CNB of RLL lung lesion using fluoroscopic guidance with FNA biopsy of the same lesion performed using CT guidance*	32408, 10009-59
CNB of RLL lung lesion and CNB of RML lung lesion using CT guidance†	32408, 32408-59
CNB of RLL lesion using CT guidance and CNB of RML lesion using MR guidance	32408, 32408-59
CNB plus FNA biopsy of RLL lung lesion using CT guidance for both, with CNB and FNA biopsy of RML lesion using CT guidance for both	32408, 32408-59, 10009-52, 10010-52
CNB of RLL lung lesion using fluoroscopic guidance, with FNA biopsy of RML lung lesion using MR guidance	32408, 10011-59
CNB of RLL lesion using CT guidance and FNA biopsy of liver lesion using US guidance‡	32408, 10005-59
CNB of RLL lesion using CT guidance and CNB of liver lesion using CT guidance	32408, 47000-59, 77012-59

Abbreviations: CNB, core needle biopsy; FNA, fine needle aspiration; MR, magnetic resonance; RLL, right lower lobe; RML, right middle lobe; US, ultrasound.
*If both CNB and FNA biopsy of a single lung lesion are performed but use different modalities of imaging guidance, both services are reported in full. A 59 modifier must be appended to one of the codes to designate that it was a separate service.
†If two lung lesions are biopsied with CNB at the same session, coding does not depend on whether the same imaging modality(ies) is used for each biopsy. Any CNB of additional lesion in the lung/mediastinum is reported with 32408-59. This may be reported for each individual lesion biopsied with CNB. For CNB of two separate lung lesions using the same imaging modality, 32408 and 32408-59 are reported. Likewise, for CNB of two separate lung lesions using different imaging modalities (eg, an RLL lesion is core biopsied using CT guidance and a separate RML lesion is core biopsied using fluoroscopic guidance), the services are reported with 32408 and 32408-59.
‡If a CNB is performed at the same setting as a biopsy of another organ using imaging guidance, both biopsies are reported and the imaging guidance for each is reported (as a bundle if included in the biopsy code, or separately if not bundled). The second biopsy is reported using 59 modifier(s) to signify that it is a separate service.

The code for core needle biopsy of the lung/mediastinum includes all imaging guidance used. The FNA codes (10004-10012) also include imaging guidance, but these codes are specific to an imaging modality. It is important to understand when the imaging guidance overlaps and should not be reported twice versus when the imaging guidance is not overlapping and may be reported twice.

The only time that the imaging modalities overlap is when a single lung lesion is biopsied using both core and FNA techniques using the same imaging guidance modality. These are considered separate services, and both biopsies may be reported. However, because the same modality(ies) of imaging guidance is used for both the FNA and the core lung biopsy of a single lesion, modifier 52 (reduced service) must be added to one of the codes so that the imaging guidance is not billed twice. For example, if both core and FNA biopsy of a single lung lesion are performed using CT guidance, 32408 and 10009-52 would be reported.

In all other cases of multiple biopsies, imaging guidance is not defined as overlapping and may be reported separately without use of a reduced services modifier. A modifier signifying that the additional biopsy is a separate service (-59) should be applied to the code(s) for any core or FNA biopsy performed after the first one.

Example cases (when performed in the same setting) and their corresponding codes are shown in Table 2.

ENDOVASCULAR VENOUS ARTERIALIZATION (TIBIAL OR PERONEAL VEIN)

●0620T Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiologic supervision and interpretation, when performed

(Continued on page 72)

(Continued from page 70)

A new category III code has been added to report endovascular venous arterialization for revascularization of the lower leg. The code is inclusive of all access, all diagnostic angiography, all ultrasound and fluoroscopic guidance and intraprocedural imaging, completion angiography, catheterizations of both arteries and veins, vessel closure(s), and placement of a covered stent to create arterial flow into the vein as an alternate route to supply arterial flow to the lower leg and foot. These services are provided in the tibial and peroneal vessels.

ADDITIONAL CODE CHANGES

High-Intensity Focused Ultrasound of the Prostate

A new category I code has been added for high-intensity–focused ultrasound (HIFU) of the prostate.

●55880 Ablation of malignant prostate tissue, transrectal, with HIFU, including ultrasound guidance

Antegrade Urography

Code 74425 has been modified to clarify its use after the service was bundled with other services such as nephrostomy placement. Instructions have been added to clarify that this code may be reported together with 50390 (aspiration of renal cyst or renal pelvis by needle), 50396 (manometric studies through nephrostomy, pyelostomy, or indwelling ureteral catheter), 50684 (injection for ureterogram or ureteropyelogram through a ureterostomy or indwelling ureteral catheter), and 50690 (antegrade loopogram/ureterography). Code 74425 is not reported with codes 50430, 50431, 50432, 50434, 50435, 50693, 50694, or 50695 because urography is included in those services.

▲74425 Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiologic supervision and interpretation

Medical Physics Dose Evaluation

●76145 Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report

Deletion of Follow-Up Ultrasound

Code 76970 (ultrasound study follow-up) was deleted in 2021. No new code was added for reporting this service.

Category III Codes for Irreversible Electroporation Ablation

Two codes are now available to report irreversible electroporation ablation (NanoKnife, AngioDynamics, Inc.).

●0600T Ablation, irreversible electroporation; one or more tumors per organ, including imaging guidance, when performed, percutaneous

●0601T One or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open

Category III Code for Pulmonary Artery Nerve Ablation

One new code was added to describe ultrasound ablation of nerves supplying the pulmonary arteries. The code includes right heart catheterization, pulmonary artery angiography, and all imaging guidance in addition to the nerve ablation.

●0632T Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance ■

Katharine L. Krol, MD, FSIR, FACR, RCCIR
Retired Interventional Radiologist
Disclosures: None.