Coding Changes for 2015

Reviewing the changes and additions to endovascular coding effective January 1.

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For the first time in several years, there are not big changes to large families of endovascular codes to contend with in 2015. There are a few changes and new codes for endovascular procedures that will be outlined in this article. In addition, there are some changes for nonvascular interventional codes that will also be discussed.

ENDOVENOUS ABLATION

The structure of the endovenous ablation family of codes remains unchanged. However, the valuations for these codes will change beginning January 1, 2015. The change in valuation was triggered by identification in screens used by the RUC (Relative Value Scale Update Committee of AMA) to identify services that may no longer be appropriately valued. Codes 36475, 36478, and 36479 are services with Medicare utilization > 10,000/year with > 100% increase in frequency from 2006 to 2011. (Even though 36476 did not meet these criteria, it was included in the review of this family of codes to determine if the assigned RUC values for these codes remained accurate several years after they were initially surveyed.) After specialty societies for physicians providing these services had reviewed the data, new RUC surveys for this family of codes were performed.

Assessment of the data from expert physicians responding to the RUC surveys found that physician time and physician work for each of these services has decreased since the codes were initially developed and valued. This is true for many new therapies and can be attributed in part to development of better tools for providing the service as well as enhancement of physician training/skill as therapies mature and experience broadens.

The data also showed that the site of service for these therapies has shifted since the original RUC survey was done. These services are now predominantly provided in outpatient and freestanding centers rather than hospital facilities. This has led to an increase in the intensity of the work done, as there are no longer hospital facilities to back up potential complications.

All of these factors were taken into consideration as new work valuations were assigned to this family of codes. In addition, this family of codes will be reviewed again by the RUC in 3 years to monitor utilization rates and valuation.

CPT Code	Descriptor	2014 wRVU	2015 wRVU
36475	Endovenous radiofrequency ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance; first vein treated	6.72	5.30
+36476	Endovenous radiofrequency ablation therapy; second and subsequent veins treated in a single extremity, each through separate access sites	3.38	2.65
36478	Endovenous laser ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance; first vein treated	6.72	5.30
+36479	Endovenous laser ablation therapy; second and subsequent veins treated in a single extremity, each through separate access sites	3.38	2.65

CAROTID STENTING

A new code to report antegrade stent placement for intrathoracic common carotid and innominate arteries goes into effect January 1, 2015.

- 37218—Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation

This code will be used to report stenting of these arteries from a femoral approach, including both percutaneous and open femoral artery access. It includes the use of distal embolic protection, when performed; selective catheterization of the vessel(s) treated; all balloon angioplasty performed before, during, or after stent deployment; closure of arteriotomy; and moderate sedation. Diagnostic angiography of the vessel(s) treated, fluoroscopic guidance and all angiography and contrast injections performed to guide the stent placement and to confirm completion of the intervention are included in the work of 37218.

This code is analogous to code 37217 (which was introduced in 2014), the CPT code used to report retrograde stenting of the intrathoracic common carotid and innominate arteries through an open neck incision. The key differentiator between codes 37217 and 37218 is antegrade versus retrograde approach to the lesion. Although the 37218 descriptor includes the option of an open approach, an open cervical access would necessitate a retrograde approach, and 37218 would not describe that service because 37218 specifies use of an antegrade approach.

The descriptors for existing codes 37215, 37216, and 37217 have been updated for 2015. These changes do not change the use of the codes, the work described by the codes, or the valuation of the codes. These changes were made to update the language in the descriptors to be consistent with other current endovascular codes and in particular to use consistent language across the carotid stent family of codes for improved clarity and to reduce potential confusion.

Δ 37215—Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection
Δ 37216— without distal embolic protection
Δ 37217—Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation

The services now reported with 37218 were previously reported with Category III codes (0075T and 0076T). The Category III codes remain active, but the descriptors have changed to reflect the change in stenting of intrathoracic common carotid and innominate arteries to Category I codes. The Category III codes are now specific for extracranial vertebral artery stent placements. In addition, open approach was also added to the descriptors for 0075T and 0076T.

Δ 0075T—Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel
+Δ 0076T— each additional vessel

ENDOVASCULAR THERAPIES FOR LOWER EXTREMITIES

A change to existing CPT codes in 2015 alters the use of codes 37220–37235 and 37236–37237. Codes 37220–37235 are now specifically to be used for the treatment of lower extremity vascular occlusive disease. This change will affect endovascular therapies in lower extremities provided for nonocclusive disease entities such as aneurysms, pseudoaneurysms, and/or rupture/extravasation. Treatment of nonocclusive lower extremity arterial disease with endovascular stent placement (either covered or noncovered) in the infrainguinal arteries will be reported with arterial vascular stent codes 37236 and 37237 rather than the lower extremity revascularization family of codes 37224–37235. The descriptors for 37236 and 37237 have been modified to reflect this change, and this change is also included in the guidance language in CPT for both sets of codes.

▲ 37236—Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for **occlusive disease,** cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery
+Δ 37237— each additional artery

Coding for iliac artery interventions will also be affected. Existing codes 37220–37223 will continue to be used for reporting endovascular therapies for occlusive disease. Existing code 34900 will continue to be used to report placement of an endoprosthesis for treatment of nonocclusive diseases (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma). Treatment of iliac artery nonvascular disease with stents that are not endoprostheses will be reported with codes 37236 and 37237.

This change will create questions for reporting therapies when both occlusive and nonocclusive disease are treated in the same vessel or in the same patient encounter. The specialty societies are working on development of consensus instructions for implementation of this coding change.

TUMOR ABLATION SERVICES

New codes for percutaneous cryoablation therapies for liver and bone tumors have been developed and will

become active in 2015, and the existing code for radiofrequency ablation of bone tumors has been modified. Code 47383 for percutaneous cryoablation of liver tumors does not include imaging guidance, which may be separately reported. Code 20983 for percutaneous cryoablation of bone tumors does include imaging guidance, and imaging guidance may not be separately reported with code 20983. Existing code 20982 was modified to include all types of imaging guidance (it previously was restricted to CT guidance only, leaving no way to appropriately report radiofrequency ablation for bone tumors when non-CT imaging guidance was used). Additional language was added to the descriptor of 20982, clarifying that this therapy also includes treatment of adjacent soft tissue tumor extension when performed. All percutaneous tumor ablation therapy codes inherently include treatment of adjacent tumor extension when the target tumor extends outside the target organ and that tumor extension is included in the field of ablation.

• 47383—Ablation, 1 or more liver tumor(s), percutaneous, cryoablation
Δ 20982—Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency
• 20983— cryoablation

Also new in the 2015 CPT Manual is a Category III code for cryoablation of pulmonary tumors. This code became effective in 2014 (Category III codes are activated January 1 and July 1 each year, unlike Category I codes, which become effective January 1 only).

• 0340T—Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, includes imaging guidance

VERTEBROPLASTY, VERTEBRAL AUGMENTATION, AND SACROPLASTY

New codes have been developed for vertebroplasty, vertebral augmentation, and sacroplasty. Changes in the structure of the new codes compared to previous codes include bundling of the surgical procedure with imaging portions of the procedure into single codes, introduction of codes for vertebroplasty performed in the cervical portion of the spine, and elevation of sacral vertebroplasty to Category I CPT codes. These codes all include bone biopsy of the vertebra when performed, moderate sedation, and all imaging necessary to perform the procedure. When procedures are performed at multiple levels, one primary code should be reported, and all additional levels should be reported with add-on code(s). Sacral procedures are reported only once per patient encounter. The Category III codes for sacroplasty (0200T, 0201T) were updated to reflect that sacral vertebroplasty is now reported with a Category I code (22511, 22512), and the Category III codes are now used only to report sacral vertebral augmentation using a balloon or other mechanical device. The Category I codes (22510–22515) are reported once for each vertebral body, regardless of whether unilateral or bilateral injections are performed. The Category III codes for sacral augmentation are structured to allow reporting of unilateral injection with 0200T and bilateral injection with 0201T. Codes 72291 and 72292 (fluoroscopic and CT guidance for vertebroplasty/vertebral augmentation/sacroplasty) were deleted. No code is available to report vertebral augmentation with balloon or other mechanical device in the cervical spine. Unlisted code for spine procedures, 22899, would be used to report this service.

• 22510—Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
• 22511— lumbosacral
+• 22512— each additional cervicothoracic or lumbosacral vertebral body
• 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— lumbar
+• 22515— each additional thoracic or lumbar vertebral body
Δ 0200T—Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, one or more needles, includes imaging guidance and bone biopsy, when performed
Δ 0201T—Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, two or more needles, includes imaging guidance and bone biopsy, when performed. ■

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