



16 | **2017 CPT coding changes**

by Albert Bothe, MD, FACS;
Megan McNally, MD, FACS;
and Jan Nagle, MS, RPh

Significant changes in Current Procedural Terminology (CPT)* coding are being implemented in 2017. Notably, new codes have been established to separately report moderate sedation when provided in conjunction with a procedure, and Appendix G in the CPT manual—“Summary of CPT Codes that Include Moderate (Conscious) Sedation”—has been eliminated. This article provides reporting information about the codes that are relevant to general surgery and its related specialties.

Moderate (conscious) sedation

In 2014, the CPT Editorial Panel and the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) convened a joint workgroup to discuss correct reporting of moderate (conscious) sedation services. This workgroup was formed after Medicare claims data demonstrated that anesthesia services were being reported for codes that include moderate sedation as inherent to the work of the physician performing a procedure. After almost two years of discussion by the joint workgroup, the CPT Editorial Panel approved the following changes for the 2017 code set:

- Creation of six new codes (99151, 99152, 99153, 99155, 99156, 99157) to report moderate sedation services in 15-minute increments
- Revision of the moderate (conscious) sedation subsection guidelines
- Deletion of the moderate sedation symbol (Ⓞ) from all codes in the CPT code set that were previously noted to inherently include moderate sedation services
- Elimination of Appendix G, “Summary of CPT Codes That Include Moderate (Conscious) Sedation”

Subsequent to the establishment of new CPT codes for moderate sedation, the Centers for Medicare &

All specific references to CPT codes and descriptions are © 2016 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.

Medicaid Services (CMS) determined that moderate sedation services furnished by the same practitioner reporting a gastrointestinal (GI) endoscopy procedure was less work than for other procedures. Therefore, CMS created a new Healthcare Common Procedure Coding System (HCPCS) code (G0500) to be reported instead of CPT code 99152.

The new HCPCS and CPT moderate sedation codes include the following (• = new code for 2017, + = add-on code):

- G0500, *Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time; patient age 5 years or older (additional time may be reported with 99153 as appropriate)*
- 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 physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age*
- 99152, *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 physiological status; initial 15 minutes of intraservice time, patient age 5 years or older*
- +•99153, *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 physiological status;*

each additional 15 minutes 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 younger than 5 years of age*
- 99156, *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 age 5 years or older*
- +•99157, *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; each additional 15 minutes intraservice time (List separately in addition to code for primary service)*

Moderate sedation relative value unit (RVU) changes

As of January 1, the physician work relative value units (wRVUs) will have been reduced for all services that previously included moderate sedation as an inherent part of the procedure. GI endoscopy procedures, with a few exceptions, will have been reduced by 0.10 wRVUs and the non-GI endoscopy procedures will be reduced by 0.25 wRVUs. These wRVU reductions match the values for the new HCPCS code G0500 (wRVU = 0.10) and new CPT code 99152 (wRVU = 0.25). If a surgeon provides moderate sedation services as described by code G0500 or code 99152, the surgeon would report both the moderate sedation code and the procedure code. However, if another provider (for example, an anesthesiologist) performs the moderate sedation service, the surgeon would only report the procedure code.

In addition to reduction in wRVUs for all codes affected by this coding change, CMS also has removed

the physician time, clinical staff time, supply, and equipment inputs related to moderate sedation. As a result, practice expense RVUs and professional liability RVUs will be decreased. However, if a surgeon performs moderate sedation and reports both the moderate sedation code and the procedure code, the net total RVU will not change.

It will be important for surgeons to determine whether non-Medicare payors recommend using G0500 or 99152 for moderate sedation for GI endoscopy procedures when moderate sedation is performed by the surgeon who also performs the procedure. Furthermore, for an endoscopy patient younger than five years old, the surgeon furnishing moderate sedation should not use HCPCS code G0500, but instead use the appropriate CPT code(s).

Table 1 on pages 19–22 identifies the GI endoscopy procedures for which HCPCS code G0500 should be used to report moderate sedation services for Medicare patients. As shown in this table, the wRVU has been reduced by 0.10 for calendar year 2017.

Selecting code(s) to report moderate sedation

Intraservice time is used to determine the appropriate code to report moderate sedation services. The intraservice time begins with the administration of the sedating agent(s) and ends when the procedure is completed, the patient is stable for recovery, and the physician or other qualified health care professional providing the sedation ends personal, continuous face-to-face time with the patient. If the physician or other qualified health care professional who provides the sedation also performs the procedure supported by sedation (99151, 99152, 99153, G0500), the physician or other qualified health care professional will supervise and direct an independent, trained observer who will assist in monitoring the patient's level of consciousness and physiological status throughout the procedure. Table 2 on page 23 provides examples to assist users in selection of the appropriate code(s) to report time spent providing moderate sedation services.

continued on page 23

TABLE 1. GI ENDOSCOPY CODES RELATED TO REPORTING CODE G0500 FOR MODERATE SEDATION FOR MEDICARE PATIENTS*

CPT / HCPCS code	Descriptor	2016 work RVU	2017 work RVU
43200	Esophagoscopy flexible transoral diagnostic	1.52	1.42
43201	Esophagoscopy flexible transoral with submucous injection	1.82	1.72
43202	Esophagoscopy flexible transoral with biopsy	1.82	1.72
43204	Esophagoscopy flex transoral injection varices	2.43	2.33
43205	Esophagoscopy flex with band ligation esophageal varices	2.54	2.44
43206	Esophagoscopy transoral with optical endomicroscopy	2.39	2.29
43211	Esophagoscopy flexible transoral mucosal resection	4.30	4.20
43212	Esophagoscopy transoral stent placement	3.50	3.40
43213	Esophagoscopy retrograde dilate balloon/other	4.73	4.63
43214	Esophagoscopy dilate esophagus balloon 30 mm	3.50	3.40
43215	Esophagoscopy flexible removal foreign body	2.54	2.44
43216	Esophagoscopy flexible lesion removal hot biopsy forceps	2.40	2.30
43217	Esophagoscopy flexible lesion removal tumor snare	2.90	2.80
43220	Esophagoscopy flexible balloon dilation <30 mm diameter	2.10	2.00
43226	Esophagoscopy flexible guide wire dilation	2.34	2.24
43227	Esophagoscopy flexible with bleeding control	2.99	2.89
43229	Esophagoscopy flex transoral lesion ablation	3.59	3.49
43231	Esophagoscopy flexible transoral ultrasound exam	2.90	2.80
43232	Esophagoscopy intra/transmural needle aspiration/biopsy	3.69	3.59
43233	Esophagogastroduodenoscopy (EGD) esophagus balloon dilation 30 mm or larger	4.17	4.07
43235	EGD transoral diagnostic	2.19	2.09
43236	EGD submucosal injection	2.49	2.39
43237	EGD ultrasound (US) scope with adjacent structures	3.57	3.47
43238	EGD intramural US needle aspirate/biopsy esophagus	4.26	4.16
43239	EGD transoral biopsy single/multiple	2.49	2.39
43240	EGD transoral transmural drainage pseudocyst	7.25	7.15
43241	EGD intraluminal tube/catheter insertion	2.59	2.49
43242	EGD intramural needle aspiration/biopsy altered anatomy	4.83	4.73
43243	EGD injection sclerosis esophageal/gastric varices	4.37	4.27
43244	EGD band ligation esophageal/gastric varices	4.50	4.40
43245	EGD dilation gastric/duodenal stricture	3.18	3.08
43246	EGD percutaneous placement gastrostomy tube	3.66	3.56
43247	EGD flexible foreign body removal	3.21	3.11
43248	EGD insert guide wire dilator passage esophagus	3.01	2.91
43249	EGD balloon dilation esophagus <30 mm diameter	2.77	2.67

*HCPCS code G0500 should be used to report moderate sedation services for Medicare patients when a surgeon performs both the moderate sedation service and the GI endoscopy procedures.

continued on next page

TABLE 1. GI ENDOSCOPY CODES RELATED TO REPORTING CODE G0500 FOR MODERATE SEDATION FOR MEDICARE PATIENTS* (CONTINUED)

CPT / HCPCS code	Descriptor	2016 work RVU	2017 work RVU
43250	EGD flex removal lesion(s) by hot biopsy forceps	3.07	2.97
43251	EGD removal tumor polyp/other lesion snare tech	3.57	3.47
43252	EGD flex transoral with optical endomicroscopy	3.06	2.96
43253	EGD US guided transmural injection/fiducial marker	4.83	4.73
43254	EGD transoral endoscopic mucosal resection	4.97	4.87
43255	EGD transoral control bleeding any method	3.66	3.56
43257	EGD deliver thermal energy sphincter/cardia gastroesophageal reflux disease	4.25	4.15
43259	EGD US exam surgical alter stomach duodenum/jejunum	4.14	4.04
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic collection specimen brushing/washing	5.95	5.85
43261	ERCP with biopsy single/multiple	6.25	6.15
43262	ERCP with sphincterotomy/papillotomy	6.60	6.50
43263	ERCP with pressure measurement sphincter of Oddi	6.60	6.50
43264	ERCP remove calculi/debris biliary/pancreas duct	6.73	6.63
43265	ERCP destruction/lithotripsy calculi any method	8.03	7.93
43274	ERCP stent placement biliary/pancreatic duct	8.58	8.48
43275	ERCP remove foreign body/stent biliary/pancreatic duct	6.96	6.86
43276	ERCP biliary/pancreatic duct stent exchange with dilation and wire	8.94	8.84
43277	ERCP balloon dilate biliary/pancreatic duct/ampulla each	7.00	6.90
43278	ERCP tumor/polyp/lesion ablation with dilation and wire	8.02	7.92
43450	Dilation esophagus unguided sound/bougie one or more pass	1.38	1.28
43453	Dilation esophagus guide wire	1.51	1.41
44360	Endoscopy upper small intestine	2.59	2.49
44361	Endoscopy upper small intestine with biopsy	2.87	2.77
44363	Enteroscopy > second portion with removal foreign body	3.49	3.39
44364	Enteroscopy > second portion with removal lesion snare	3.73	3.63
44365	Enteroscopy > second portion with removal lesion cautery	3.31	3.21
44366	Enteroscopy > second portion with control bleeding	4.40	4.30
44369	Enteroscopy > second portion ablation lesion	4.51	4.41
44370	Enteroscopy > second portion transendoscopic stent placement	4.79	4.69
44372	Enteroscopy > second portion with placement percutaneous tube	4.40	4.30
44373	Enteroscopy > second portion conversion to jejunostomy tube	3.49	3.39
44376	Enteroscopy > second portion with ileum with or without collection spec	5.25	5.15
44377	Enteroscopy > second portion with ileum with biopsy single/multiple	5.52	5.42
44378	Enteroscopy > second portion ileum control bleeding	7.12	7.02

*HCPCS code G0500 should be used to report moderate sedation services for Medicare patients when a surgeon performs both the moderate sedation service and the GI endoscopy procedures.

continued on next page

TABLE 1. GI ENDOSCOPY CODES RELATED TO REPORTING CODE G0500 FOR MODERATE SEDATION FOR MEDICARE PATIENTS* (CONTINUED)

CPT / HCPCS code	Descriptor	2016 work RVU	2017 work RVU
44379	Enteroscopy > second portion with ileum with stent placement	7.46	7.36
44380	Ileoscopy thru stoma diagnostic with collection spec when performed	0.97	0.87
44381	Ileoscopy thru stoma with balloon dilation	1.48	1.38
44382	Ileoscopy thru stoma with biopsy single/multiple	1.27	1.17
44384	Ileoscopy thru stoma with placement of endoscopic stent	2.95	2.85
44385	Endoscopic evaluation intestinal pouch diagnostic with collection spec	1.30	1.20
44386	Endoscopic evaluation intestinal pouch with biopsy single/multiple	1.60	1.50
44388-53	Colonoscopy thru stoma diagnostic including collection spec	1.41	1.36
44388	Colonoscopy thru stoma diagnostic including collection spec	2.82	2.72
44389	Colonoscopy thru stoma with biopsy single/multiple	3.12	3.02
44390	Colonoscopy thru stoma with removal foreign body	3.84	3.74
44391	Colonoscopy thru stoma control bleeding	4.22	4.12
44392	Colonoscopy thru stoma removal lesion by hot biopsy forceps	3.63	3.53
44394	Colonoscopy thru stoma with removal tumor polyp/other lesion by snare	4.13	4.03
44401	Colonoscopy thru stoma ablation lesion	4.44	4.34
44402	Colonoscopy thru stoma with endoscopic stent placement	4.80	4.70
44403	Colonoscopy thru stoma with endoscopic mucosal resection	5.60	5.50
44404	Colonoscopy thru stoma with submucosal injection	3.12	3.02
44405	Colonoscopy thru stoma with balloon dilation	3.33	3.23
44406	Colonoscopy thru stoma with ultrasound exam	4.20	4.10
44407	Colonoscopy thru stoma with US guided needle aspiration/biopsy	5.06	4.96
44408	Colonoscopy thru stoma with decompression	4.24	4.14
44500	Introduction of long gastrointestinal tube (separate procedure)	0.49	0.39
45303	Proctosigmoidoscopy rigid with dilation	1.50	1.40
45305	Proctosigmoidoscopy rigid with biopsy single/multiple	1.25	1.15
45307	Proctosigmoidoscopy rigid with removal foreign body	1.70	1.60
45308	Proctosigmoidoscopy rigid removal one lesion cautery	1.40	1.30
45309	Proctosigmoidoscopy rigid removal one lesion snare	1.50	1.40
45315	Proctosigmoidoscopy rigid removal multi-tumor by cautery/snare	1.80	1.70
45317	Proctosigmoidoscopy rigid control bleeding	2.00	1.90
45320	Proctosigmoidoscopy rigid ablation lesion	1.78	1.68
45321	Proctosigmoidoscopy rigid decompression volvulus	1.75	1.65
45327	Proctosigmoidoscopy rigid transendoscopic stent placement	2.00	1.90
45332	Sigmoidoscopy flexible with removal foreign body	1.86	1.76

*HCPCS code G0500 should be used to report moderate sedation services for Medicare patients when a surgeon performs both the moderate sedation service and the GI endoscopy procedures.

continued on next page

TABLE 1. GI ENDOSCOPY CODES RELATED TO REPORTING CODE G0500 FOR MODERATE SEDATION FOR MEDICARE PATIENTS* (CONTINUED)

CPT / HCPCS code	Descriptor	2016 work RVU	2017 work RVU
45333	Sigmoidoscopy flexible with removal tumor by hot biopsy forceps	1.65	1.55
45334	Sigmoidoscopy flexible control bleeding	2.10	2.00
45335	Sigmoidoscopy flexible directed submucosal injection any substance	1.14	1.04
45337	Sigmoidoscopy flexible with decompression with placement of tube	2.20	2.10
45338	Sigmoidoscopy flexible removal tumor, polyp, or other lesion by snare	2.15	2.05
45340	Sigmoidoscopy flexible transendoscopic balloon dilatation	1.35	1.25
45341	Sigmoidoscopy flexible transendoscopic US exam	2.22	2.12
45342	Sigmoidoscopy flexible transendoscopic US-guided needle aspiration/biopsy	3.08	2.98
45346	Sigmoidoscopy flexible ablation tumor polyp/other les	2.91	2.81
45347	Sigmoidoscopy flexible placement of endoscopic stent	2.82	2.72
45349	Sigmoidoscopy flexible with endoscopic mucosal resection	3.62	3.52
45350	Sigmoidoscopy flexible with band ligation(s)	1.78	1.68
45378-53	Colonoscopy flexible diagnostic with collection spec when performed	1.68	1.63
45378	Colonoscopy flexible diagnostic with collection spec when performed	3.36	3.26
G0105-53	Screening colonoscopy on individual at high risk	1.68	1.63
G0105	Screening colonoscopy on individual at high risk	3.36	3.26
G0121-53	Screening colonoscopy on individual not high risk	1.68	1.63
G0121	Screening colonoscopy on individual not high risk	3.36	3.26
45379	Colonoscopy flexible with removal of foreign body(s)	4.38	4.28
45380	Colonoscopy flexible with biopsy single/multiple	3.66	3.56
45381	Colonoscopy flexible with directed submucosal injection any substance	3.66	3.56
45382	Colonoscopy flexible with control bleeding any method	4.76	4.66
45384	Colonoscopy flexible with removal lesion by hot biopsy forceps	4.17	4.07
45385	Colonoscopy flexible with removal of tumor polyp lesion by snare	4.67	4.57
45386	Colonoscopy flexible with transendoscopic balloon dilatation	3.87	3.77
45388	Colonoscopy flexible ablation tumor polyp/other lesion	4.98	4.88
45389	Colonoscopy flexible with endoscopic stent placement	5.34	5.24
45390	Colonoscopy flexible with endoscopic mucosal resection	6.14	6.04
45391	Colonoscopy flexible with limited endoscopic US exam	4.74	4.64
45392	Colonoscopy flexible with US-guided needle aspiration/biopsy with limited endoscopic US exam	5.60	5.50
45393	Colonoscopy flexible with decompression	4.78	4.68
45398	Colonoscopy flexible with band ligation(s)	4.30	4.20

*HCPCS code G0500 should be used to report moderate sedation services for Medicare patients when a surgeon performs both the moderate sedation service and the GI endoscopy procedures.

TABLE 2.
MODERATE SEDATION
CODING GUIDANCE

Total intraservice time for moderate sedation	Patient age	Moderate sedation (MS) provided by physician or other qualified health care professional (SAME physician or qualified health care professional also performing the procedure MS is supporting)	MS provided by different physician or other qualified health care professional (NOT the physician or qualified health care professional who is performing the procedure MS is supporting)
		Code(s)	Code(s)
Less than 10 minutes	Any age	Not separately reported	Not separately reported
10–22 minutes	<5 years	99151	99155
10–22 minutes	5 years or older	99152*	99156
23–37 minutes	<5 years	99151 + 99153 × 1	99155 + 99157 × 1
23–37 minutes	5 years or older	99152* + 99153 × 1	99156 + 99157 × 1
38–52 minutes	<5 years	99151 + 99153 × 2	99155 + 99157 × 2
38–52 minutes	5 years or older	99152* + 99153 × 2	99156 + 99157 × 2
53–67 minutes	<5 years	99151 + 99153 × 3	99155 + 99157 × 3
53–67 minutes	5 years or older	99152* + 99153 × 3	99156 + 99157 × 3
68–82 minutes	<5 years	99151 + 99153 × 4	99155 + 99157 × 4
68–82 minutes	5 years or older	99152* + 99153 × 4	99156 + 99157 × 4
83 minutes or longer	<5 years	Add 99153	Add 99157
83 minutes or longer	5 years or older	Add 99153	Add 99157

*For Medicare patients, report HCPCS code G0500 for GI endoscopy procedures instead of CPT code 99152.

Reprinted with permission, American Medical Association.

CPT five-digit codes, two-digit number modifiers, and descriptions only are copyright of the AMA. No payment schedules, fee schedules, RVUs, scales, conversion factors, or components thereof are included in CPT. The AMA is not recommending that any specific relative values, fees, payment schedules, or related listings be attached to CPT. Any RVUs or relative listings assigned to CPT codes are not those of the AMA, and the AMA is not recommending use of these relative values.

Amputation of tuft of distal phalanx

Code 11752, *Excision of nail and nail matrix, partial or complete (for example, ingrown or deformed nail), for permanent removal; with amputation of tuft of distal phalanx*, was deleted from the 2017 CPT code set. It was determined that the work inherent to this procedure was widely variable and appropriate treatment depended on the patient presentation and diagnosis. For example, fingertip amputations are described according to the angle of loss (lateral, dorsal, transverse, palmar), skeletal loss (soft tissue only, tuft, shaft, base) and zone of injury relating to mechanism of injury (sharp, crush, saw blade, thermal knife). Treatment is individualized for each patient based on these and other factors. For correct reporting, see codes 26236, *Partial excision (craterization, saucerization, or diaphysectomy) bone (for example, osteomyelitis); distal phalanx of finger*; code 28124, *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (for example, osteomyelitis or bossing); phalanx of toe*; or code 28160, *Hemiphalangectomy*

or interphalangeal joint excision, toe, proximal end of phalanx, each. In addition, procedures related to skin (for example, pinch graft) may be separately reported when performed.

Excisional bone biopsy

In 2014, the RUC identified two codes used to report excisional bone biopsy (20240, 20245) as potentially misvalued in the Medicare physician fee schedule (MPFS) because the codes included more than one postoperative visit within the 010 global period. After review by the RUC, it was determined that both codes had wide variability in postoperative care and, therefore, both codes should have a 000 global period assignment; CMS agreed to this change. For 2017, both codes have a 000 global assignment and the code descriptors have been revised to include additional examples of bones to differentiate superficial bones from deep bones (▲ = revised code for 2017):

▲20240, *Biopsy, bone, open; superficial (for example, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)*

▲20245, *Biopsy, bone, open; deep (for example, humeral shaft, ischium, femoral shaft)*

Mechanochemical ablation therapy of incompetent vein(s)

The CPT code set includes a number of codes to report the treatment of venous disease such as varicose veins and incompetence of truncal veins, including the following: direct puncture sclerotherapy with or without local anesthesia (36468, 36470, 36471); stab phlebectomy under local anesthesia (37765, 37766); laser or radiofrequency thermal ablation utilizing tumescent anesthesia (36475, 36476, 36478, 36479); and surgical vein ligation and/or vein stripping under monitored or general anesthesia (37700–37761, 37780–37785).

As of January 1, two new codes may be used to describe mechanochemical ablation (MOCA) therapy of incompetent lower extremity vein(s). The MOCA procedure can be performed using local anesthesia without the need for tumescent (peri-saphenous) anesthesia and involves concomitant use of an intraluminal device that mechanically disrupts/abrades the venous intima, and infusion of a physician-specified medication in the target vein(s). This ablation method does not use thermal energy; therefore, the potential for nerve damage is minimized. The following two new codes are used to describe MOCA therapy:

•36473, *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated*

+•36474, *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)*

Note that for catheter injection of sclerosant without concomitant endovascular mechanical disruption of

the vein intima or for catheter injection of an adhesive, code 37799, *Unlisted procedure, vascular surgery*, should be reported.

Dialysis circuit

The Joint CPT/RUC Workgroup on Codes Reported Together Frequently identified codes related to dialysis circuit interventions that are frequently reported together in various combinations. This required creation of *bundled* codes for reporting these services. The arteriovenous (AV) dialysis circuit is designed for easy and repetitive access to perform hemodialysis. It begins at the arterial anastomosis and extends to the right atrium. The circuit may be created using either an arterial-venous anastomosis, known as an arteriovenous fistula, or a prosthetic graft placed between an artery and vein, known as an arteriovenous graft. The dialysis circuit comprises two segments: (1) the peripheral dialysis segment, and (2) the central dialysis segment. For 2017, the CPT Editorial Panel established nine new bundled codes to report angioplasty, stent placement, thrombectomy, embolization, and radiological supervision and interpretation within the dialysis circuit, including the following:

•36901, *Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow, including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report*

•36902, *with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty*

•36903, *with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment*

- 36904, Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)
- 36905, with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty
- 36906, with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit
- +•36907, Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)
- +•36908, Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)
- +•36909, Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)

Esophageal sphincter augmentation with magnetic band

Two new codes (43284, 43285) were established to report laparoscopic implantation and to report removal of a magnetic bead sphincter augmentation device for treatment of gastroesophageal reflux disease (GERD). With establishment of these codes, the following two CPT Category III codes (0392T, 0393T) were deleted:

- 43284, Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed
- 43285, Removal of esophageal sphincter augmentation device

Abdominal aortic aneurysm screening

A new CPT Category I code (76706) was established to report abdominal aortic aneurysm (AAA) screening. An AAA is a weakening in the wall of the infrarenal aorta that typically results in an increased anteroposterior diameter of 3 cm or greater in the adult population. AAAs are often undiagnosed because a large proportion of patients are asymptomatic until the development of rupture, which is generally acute and often fatal. Screening is recommended to identify those patients who may be at increased risk and to assist in early detection.

The U.S. Preventive Services Task Force recommends one-time screening for AAA with ultrasonography in men ages 65 to 75 years who have smoked, and recommends screening for AAA be offered selectively to men ages 65 to 75 who have never smoked. Code 76706 will replace HCPCS code G0389, *Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening*, which is deleted for 2017.

In addition, it is inappropriate to report code 76770, *Ultrasound, retroperitoneal (for example, renal, aorta, nodes), real time with image documentation; complete*, or code 76775, *Ultrasound, retroperitoneal for example, renal, aorta, nodes), real time with image documentation; limited*, for AAA screening. Rather, use the following code:

- 76706, *Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)* ♦

Note

Accurate coding is the responsibility of the provider. This summary is intended to serve only as a resource to assist in the billing process.