Radiology Coding & Reimbursement Update for 2017

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Coding Strategies® provides exceptional consulting and educational services designed to improve compliance and ensure appropriate reimbursement for the financial health of your business.
2016 MPFS & OPPS Updates

MPFS Reimbursement
- The Conversion Factor is $35.8887
- Estimated Overall Impacts
  - Radiology: -1%, Interventional Radiology: -1%, Nuclear Medicine: 0%

MPPR
- As required by the Consolidated Appropriations Act of 2015, CMS is reducing the professional component payment reduction for multiple advanced imaging exams from 25% to 5% effective January 1, 2017.

Clinical Decision Support
- Anticipated implementation date of 1/1/18
- Approved CDS Mechanisms will be announced by 6/30/2017
- How information will be reported will not be announced until the FY18 cycle
- 8 priority clinical areas (required for the mechanisms)
  - Coronary artery disease (suspected or diagnosed)
  - Suspected pulmonary embolism
  - Headache (traumatic and non-traumatic)
  - Hip pain
  - Low back pain
  - Shoulder pain (to include suspected rotator cuff)
  - Cancer of the lung (primary or metastatic, suspected or diagnosed)
  - Cervical or neck pain

OPPS Overall Reimbursement
- CMS has increased the OPPS conversion factor by 1.65%
- Hospitals that fail to meet quality reporting requirements receive a reduced conversion factor of 2%

APC Changes
- Further restructured APCs for imaging services
  - Consolidated from 17 APCs in 2016 to 7 in 2017
  - Excludes IR and nuclear medicine services
- Establishes 25 additional C-APCs
  - 5072 – Level 2 excision/biopsy/I&D – perc breast bx
  - 5314 – Abd/peritoneal/biliary & related procedures
  - 5373/5374 – Level 3 & 4 urology & related services
Packaging
- Expanded the number of conditionally packaged services (status Q1 and Q2) to align the packaging logic at the claim level (versus DOS)
- Will package more services together and lower payments

Site Neutral Payment
- Section 603 of the Bipartisan Budget Act of 2015
- Establishes a site-neutral payment policy for newly-acquired, provider-based, off-campus hospital outpatient department (HOPD) after 11/2/2015
- Addresses the concern that HOPD services are paid more than same services provided at ASCs, physicians officers and/or community OP facilities
- Requires that items or services that are furnished on or after 1/1/17 be reimbursed through the MPFS or ASC payment system instead of OPPS which reimburses at a much lower rate for many procedures
- It specifically defines an off-campus outpatient department as one that is located more than 250 yards from the hospital’s main campus
- This relates to new facilities that are established after 11/2/15
- Hospital OP departments billing under OPPS prior to 11/2/15 are “grandfathered” and not impacted
- Only applies to off-campus hospital departments (PBD) and does not include satellite hospital facilities or hospital owned, provided-based entities such as home health agencies or skilled nursing facilities.
- Also does not apply to dedicated EDs
- Does not directly affect reimbursement under Medicaid, Medicare Advantage or commercial insurance
- Exemptions
  - Dedicated Emergency Departments
  - Off-campus PBDs that were furnishing and billing prior to 11/2/2015
  - Services furnished in a hospital department within 250 yards of a remote location of the hospital
  - New entities with a signed construction agreement in place 11/2/2015 (Final Rule 2016 – have legal counsel review)
  - An off-campus PBD will lose its exemption if it relocates (except for emergency approved circumstances)

  “PN” Modifier – Non-exceptioned service provided at an off-campus outpatient, provider-based department of a hospital
  - Must be appended to all codes for all nonexcepted services
    - UB04 only (not CMS1500)
    - Not limited to Radiology – this is for all services
    - These services will be paid under the MPFS

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• “PO” Modifier – Excepted service provided at an off-campus outpatient, provider-based department of a hospital

Other Payment Discounts
• Consolidated Appropriations Act of 2016 requires a Medicare payment reduction of 20% for x-rays taken using film rather than digital radiography
• Applies to:
  – Hospital payments under OPPS
  – TC payments under MPFS including the TC portion of global payments
• “FX” modifier
  – Required modifier to indicate that a film x-ray was taken (as opposed to digital)
  – Triggers the required 20% payment reduction required by the Consolidated Appropriations Act of 2016 for x-rays taken using film rather than digital radiography
• CR vs DR
  – Reimbursement for Computed Radiography (CR) will be reduced by 7% from 1/1/2018-12/31/2022
  – Reduction is increased to 10% beginning in 2023 and all subsequent years
  – No guidance yet on how to report
    • Anticipate information in 2018 rule making cycle

HEUs
• CMS will continue paying hospitals an additional $10 for TC-99m isotopes produced using non-highly enriched uranium.

Other Regulatory Updates – 2017 NCCP Updates
• MUE and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians should not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.
• Comparative Imaging Studies
  • Imaging studies following procedures like fracture reduction or intubation to look for complications and to check the results of the procedure.
  • Per NCCP – Chapter 9 the PC of these studies are not separately reportable if performed by the same physician/group
  • Can bill if following intubation by a different physician/group
• Diagnostic + W/Guidance
  • All Ultrasound, CT, & MR guidance includes diagnostic studies of the same modality of the same anatomic area on the same day, even if the diagnostic imaging was performed during a separate encounter.

2017 CPT Coding Updates

Diagnostic Changes
• Breast Imaging
• Ultrasound for AAA Screening
• NIPS
• Lung Cancer Screening Code
• Radiopharmaceuticals
Mammograms

- Effective January 1, 2017 all mammo codes can be used for digital, film, or CR mammograms.
- Remember modifier FX if film is utilized
- CAD is now bundled into all mammogram codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77065</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral</td>
</tr>
<tr>
<td>77066</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral</td>
</tr>
<tr>
<td>77067</td>
<td>Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed</td>
</tr>
</tbody>
</table>

- Medicare still requires G-codes (revised for 2017)

<table>
<thead>
<tr>
<th>Code</th>
<th>2017 Description</th>
<th>2016 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0202</td>
<td>Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed</td>
<td>Screening mammography, producing direct digital image, bilateral, all views</td>
</tr>
<tr>
<td>G0204</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral</td>
<td>Diagnostic mammography, producing direct 2D digital image, bilateral, all views</td>
</tr>
<tr>
<td>G0206</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral</td>
<td>Diagnostic mammography, producing direct 2D digital image, unilateral, all views</td>
</tr>
</tbody>
</table>

- For electrical impedance breast scan use 76499 (UPC)

Ultrasound for AAA Screening

- G0389 has been replaced with a category I code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76706</td>
<td>Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)</td>
</tr>
</tbody>
</table>

Contrast Ultrasound of the Abdomen

- A new HCPCS code has been added for 2017
  - C9744 – Ultrasound, abdominal, with contrast
- New imaging code for IV contrast agent used for ultrasound of the liver as well as echocardiograms
  - Q9950 - Injection, sulfur hexafluoride lipid microspheres, per ml
NIPS
- Complete bilateral code 93965 for Noninvasive Physiologic Studies of Extremity Veins has been deleted
- New Notes in CPT® Manual
  - *Physiologic studies* Noninvasive physiologic studies are performed using equipment *separate and distinct* from the duplex ultrasound imager.
  - Codes 93922-93924 describe evaluation of non-imaging physiologic recording of pressures with Doppler analysis of bi-directional blood flow, plethysmography, and/or oxygen tension measurements appropriate for the anatomic area studied

Lung Cancer Screening
- The S code for LDCT (S8032) has been deleted effective 10/1/2016

Radiopharmaceuticals
- New Q codes went into effect on 7/1/16 and C codes were deleted

<table>
<thead>
<tr>
<th>New 2017 Codes</th>
<th>Deleted 2016 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9982 Flutemetamol f18,</td>
<td>C9459 Flutemetamol f18,</td>
</tr>
<tr>
<td>per study dose, up to 5</td>
<td>diagnostic, per</td>
</tr>
<tr>
<td>millicuries</td>
<td>study dose, up to 5</td>
</tr>
<tr>
<td>Q9983 Florbetaben f18,</td>
<td>C9458 Florbetaben f18,</td>
</tr>
<tr>
<td>diagnostic, per study</td>
<td>diagnostic, per</td>
</tr>
<tr>
<td>dose, up to 8.1</td>
<td>study dose, up to 8.1</td>
</tr>
<tr>
<td>millicuries</td>
<td></td>
</tr>
</tbody>
</table>

- A code for C-11 goes into effect 1/1/17 and the C code will be deleted

<table>
<thead>
<tr>
<th>New 2017 Codes</th>
<th>Deleted 2016 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9515 Choline c-11,</td>
<td>C9461 Choline c 11,</td>
</tr>
<tr>
<td>diagnostic, per study</td>
<td>diagnostic, per</td>
</tr>
<tr>
<td>dose up to 20</td>
<td>study dose</td>
</tr>
<tr>
<td>millicuries</td>
<td></td>
</tr>
</tbody>
</table>

- The Bexxar codes A9544, A9545 and G3001 have been deleted
Interventional Changes

- Fluoroscopic Guidance
- Conscious/Moderate Sedation
- Endovenous Ablation Procedures/Sclerotherapy
- Angioplasty
- Dialysis Circuit Maintenance
- Spinal Procedures

Fluoroscopic Guidance

- Turned into add-on codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+77002</td>
<td>Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>+77003</td>
<td>Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

- A new note that states “If imaging guidance is performed see 76942, 77002, 77012, 77021” has been added under the following codes:
  - 10160 (Puncture aspiration of abscess, hematoma, bulla, or cyst)
  - 20206 (Biopsy, muscle, percutaneous needle)
  - 38505 (Lymph node biopsy, superficial)
  - 55700 (Prostate)

Moderate Sedation

- Bulls-eye: previously identified services that inherently included moderate sedation (deleted for 2017)
  - This impacted a long list of codes and will show as “revised” in the CPT® Manual
- Moderate section can now be coded separately for procedures formerly in Appendix G of the CPT® manual
  - Appendix G is being eliminated for 2017
- 6 new CPT codes for moderate sedation whenever it is provided
- 99143 – 99145 have been deleted replaced with:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99151</td>
<td>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</td>
</tr>
<tr>
<td>99152</td>
<td>; initial 15 minutes of intraservice time, patient age 5 years or older</td>
</tr>
<tr>
<td>+99153</td>
<td>; each additional 15 minutes intraservice time (List separately in addition to code for primary service)</td>
</tr>
</tbody>
</table>
Moderate Sedation (con’t)
- 99148 – 99150 have been deleted replaced with

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99155</td>
<td>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</td>
</tr>
<tr>
<td>99156</td>
<td>; initial 15 minutes of intraservice time, patient age 5 years or older</td>
</tr>
<tr>
<td>+99157</td>
<td>; each additional 15 minutes intraservice time (List separately in addition to code for primary service)</td>
</tr>
</tbody>
</table>

- Not used to report administration of medications for pain control, minimal sedation, deep sedation, or monitored anesthesia care
- Independent trained observer
  - Qualified to monitor the patient during the procedure, has no other duties (eg, assisting at surgery) during the procedure
  - Pre and Post service work not separately reported
- Intraservice work is used to determine the appropriate code (i.e., time)
  - Begins with administration of sedating agent
  - Ends when physician (or OQHP) providing the sedation ends personal continuous face/face time with the patient

Endovenous Radiofrequency & Laser Ablation
- Add on codes revised for 2017 to state “subsequent vein(s)”
- Only 1 unit of 36476 & 36479 can be reported per leg
- Codes include all image guidance & monitoring

Mechanochemical Ablation
- Mechanically disrupts/abrades the venous intima and infuses specified medication in the target vein(s)
- ClariVein® IC (Vascular Insights)
- Performed under local anesthesia (versus tumescent anesthesia)
- New codes for 2017
- Only 1 unit of 36474 can be reported per leg
- Codes include all image guidance & monitoring
- Codes require both the mechanical disruption and the injection/infusion of medication
- Catheter injection of a sclerosing agent without mechanical disruption should be assigned 37799
- Syringe injection of sclerosant is assigned as sclerotherapy

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36473</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechnochemical; first vein treated</td>
</tr>
<tr>
<td>+36474</td>
<td>... subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>
Other Angioplasty

• New codes for arterial and venous angioplasty
• Used for both open and percutaneous procedures
• Cutting, drug-coated & cryoplasty balloons
• Codes should not be used for angioplasty of:
  • Lower extremity arteries for occlusive disease
  • Intracranial, coronary or pulmonary arteries
  • Dialysis circuit when approached through the circuit
  • Same vessel as stent placement
  • Aorta or visceral arteries in conjunction with fenestrated endovascular repair
• Report once per vessel
• Angioplasty performed on 2 vessels via single balloon inflation should be considered a single procedure
• Add-on codes should be used when add’l separate and distinct vessels are treated
  • For both same & opposite sides
• Some items may be separately reported
  • Code Separately
    • Diagnostic angiograms, Catheter placement, IVUS, & Thrombectomy or thrombolysis
  • Included (do not code separately)
    • Radiological S&I and Completion angiograms

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>37246</td>
<td>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</td>
</tr>
<tr>
<td>+37247</td>
<td>… each additional artery (List separately....)</td>
</tr>
<tr>
<td>37248</td>
<td>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</td>
</tr>
<tr>
<td>+37249</td>
<td>… each additional vein (List separately....)</td>
</tr>
</tbody>
</table>
**Dialysis Circuit Procedures**

<table>
<thead>
<tr>
<th>Service</th>
<th>With Thrombectomy</th>
<th>Without Thrombectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral stent placement</td>
<td>36906</td>
<td>36903</td>
</tr>
<tr>
<td>Peripheral angioplasty (no stent)</td>
<td>36905</td>
<td>36902</td>
</tr>
<tr>
<td>No peripheral stent or angioplasty</td>
<td>36904</td>
<td>36901</td>
</tr>
<tr>
<td>Central stent placement</td>
<td></td>
<td>Add +36908</td>
</tr>
<tr>
<td>Central angioplasty (no stent)</td>
<td></td>
<td>Add +36907</td>
</tr>
<tr>
<td>Embolization</td>
<td></td>
<td>Add +36909</td>
</tr>
</tbody>
</table>

- **“Dialysis circuit” = AV fistulas & AV grafts**
- Unique code sets for both diagnostic and therapeutic services
- All new codes for 2017!
- Peripheral Segment
  - Begins at the arterial anastomosis and extends to the central segment
  - Includes the previously defined “peri-anastomotic region”
  - For most circuits the segment extends through the axillary vein
  - If the cephalic vein is the outflow vein then the segment extends thru the entire cephalic vein
  - If the circuit is in the leg the segment extends through the common femoral vein
- Central Segment
  - Extends from the peripheral segment to the right atrium
  - For leg circuits the central segment includes the Ext iliac vein, common iliac vein and IVC

- **Diagnostic Imaging Only 36901**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36901</td>
<td>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;</td>
</tr>
</tbody>
</table>

- Represents a diagnostic imaging study of an AV shunt when a therapeutic intervention is not performed
- Includes antegrade and/or retrograde punctures, contract injection(s) and the diagnostic imaging
- Includes all catheter manipulation necessary for diagnostic imaging including:
  - Passing the catheter further into the circuit or into the central veins (including IVC if necessary)
  - Selective catheterization of the venous side branches
  - Passing the catheter tip thru the arterial anastomosis for adequate imaging of the anastomosis
Dialysis Circuit Procedures (con't)

- Diagnostic Imaging Only 36901 (con't)
  - Does not include catheterization and imaging of the arterial inflow proximal to the peri-anastomotic segment.
  - Arterial inflow is separately reported (eg, 36215, but not 36200) if catheter advanced to a location proximal to and distinct from the arterial anastomosis
  - For example, imaging performed via a pre-existing access or via an access other than a direct puncture of the fistula
  - In this case modifier 52 should be appended to 36901

- Peripheral Segment PTA & Stenting – 36902-36903

<table>
<thead>
<tr>
<th>Codes</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>36902</td>
<td>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; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty</td>
</tr>
<tr>
<td>36903</td>
<td>. . . 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</td>
</tr>
</tbody>
</table>

- Codes include:
  - 1+ punctures of the circuit
  - Diagnostic imaging
  - All catheterizations required to perform the intervention
  - Angiography, fluoro guidance, roadmapping & RS&I to perform the intervention
  - Closure of the puncture by any method

- PTA 36902
  - Includes PTA of 1 or more lesions of the peripheral segment
    - Includes the per-anastomotic region when performed
  - Only 1 unit can be reported per session
  - Does not include use of a balloon to remove an arterial plug

- Stent 36903
  - Includes placement of 1 or more stents in the peripheral segment
  - Includes any PTA performed in the peripheral segment
  - Only 1 unit can be reported per session
Dialysis Circuit Procedures (con’t)

- **Thrombectomy – 36904-36906**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>36904</td>
<td>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 intra-procedural pharmacological thrombolytic injections(s);</td>
</tr>
<tr>
<td>36905</td>
<td>... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty</td>
</tr>
<tr>
<td>36906</td>
<td>... 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</td>
</tr>
</tbody>
</table>

- Coding for a declot, by any method, includes declotting the entire graft.
  - Multiple passes
  - Multiple methods
    - Mechanical Device
    - Fogarty Catheter
    - TPA
- Codes are used for peripheral and/or central segment(s)
- Performance of additional services is what drives code selection
- Read definitions closely
- Codes include:
  - 1+ punctures of the circuit
  - Diagnostic imaging
  - Catheter placements
  - All maneuvers required to remove thrombus from the peripheral or central segments
  - Angiography, fluoro guidance, roadmapping & RS&I to perform the intervention
  - Closure of the puncture by any method

- **Central Segment PTA & Stenting – 36907-36908**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>+36907</td>
<td>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)</td>
</tr>
<tr>
<td>+36908</td>
<td>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)</td>
</tr>
</tbody>
</table>
Dialysis Circuit Procedures (con’t)

- **Central Segment PTA & Stenting – 36907-36908 (con’t)**
  - Codes can be reported with:
    - Dialysis circuit imaging (36901)
    - Peripheral segment PTA & Stent (36902-36903)
    - Thrombectomy (36904-36906)
    - Open dialysis circuit creation, revision, and thrombectomy (36818-36833)
  - Stent – 36908
    - Includes placement of 1 or more stents in the central segment
    - Includes any PTA performed in the central segment
    - Only 1 unit can be reported per session
  - Do not use codes 36907 & 36908 when central segment PTA and stent placement are performed via remote access
    - Use general venous PTA codes or general venous stent placement codes

- **Embolization – 36909**

<table>
<thead>
<tr>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>+36909</td>
<td>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)</td>
</tr>
</tbody>
</table>

- Venous collaterals are side branches off the dialysis circuit
- New add-on code for embolization of accessory veins as well as main dialysis circuit
- Code can be reported with:
  - Dialysis circuit imaging (36901)
  - Peripheral segment PTA & Stent (36902-36903)
  - Thrombectomy (36904-36906)
- Only 1 unit can be reported per session regardless of how many vessels are embolized
- Separate codes should not be assigned for catheterization of venous collaterals
  - Already included in base codes
Spinal Injections

- Injections for spinal procedures replaced with 8 new codes
- Injection of contrast during fluoroscopic guidance and localization is inclusive
- Fluoroscopic guidance and localization is reported with 77003, unless a formal contrast study (Myelography, epidurography, or arthrography) is performed.
- Image guidance and the injection of contrast are inclusive components and required for the performance of Myelography, as described by codes 62302-62305.
- Code choice is based on the region at which the needle or catheter entered the body (eg, lumbar).
- Codes should be reported only once, when the substance injected spreads or catheter tip insertion moves into another spinal region.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>62320</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) … cervical or thoracic; without imaging guidance</td>
</tr>
<tr>
<td>62321</td>
<td>; with imaging guidance (ie, fluoroscopy or CT)</td>
</tr>
<tr>
<td>62322</td>
<td>Injection(s), of diagnostic or therapeutic substance(s)…. lumbar or sacral (caudal); without imaging guidance</td>
</tr>
<tr>
<td>62323</td>
<td>; with imaging guidance (ie, fluoroscopy or CT)</td>
</tr>
<tr>
<td>62324</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) … , cervical or thoracic; without imaging guidance</td>
</tr>
<tr>
<td>62326</td>
<td>Injection(s), including indwelling catheter placement, …, lumbar or sacral (caudal); without imaging guidance</td>
</tr>
<tr>
<td>62327</td>
<td>; with imaging guidance (ie, fluoroscopy or CT)</td>
</tr>
</tbody>
</table>

**Summary**

- Lots of new changes for 2017
- Not all changes are simple coding changes
- There will be more changes throughout 2017
- Ensure you have your Coding Strategies Navigators with complementary Supplements

**Thank You!**

**Speaker Contact Information**

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