ERRATA for
Interventional Radiology Coding Reference
2017 Edition

Text deletions are ~~crossed out~~. New text is **blue and bolded**. Ordered by appearance in text.

Page 19, Modifier Table

MODIFIER	DESCRIPTION	USAGE	EFFECT ON MEDICARE PAYMENT
PN	Non-excepted Service Provided at an Off-campus, Outpatient, Provider-based Department of a Hospital	Append to procedure codes when billing the technical component of visits and procedures performed in an off-campus provider-based department of a hospital **that was NOT billing for covered outpatient provider department (OPD) services furnished prior to November 2, 2015**.	~~The payment will be determined by a new fee schedule based on the physician fee schedule. It is anticipated to be about 50% of the OPPS payment and will include bundling of payment for services based on OPPS rules.~~ **Payment is made using the OPPS fee schedule with additional discounting to align the payment with that for the same service when reimbursed under the physician fee schedule.**
PO	**Excepted Service Provided at an Off-campus, Outpatient, Provider-based Department of a Hospital**	**Append to procedure codes when billing the technical component of visits and procedures performed in an off-campus provider-based department of a hospital that WAS billing for covered outpatient provider department (OPD) services furnished prior to November 2, 2015.**	**No effect on payment.**

Page 37, Modifier Descriptions

MODIFIER PN – NON-EXCEPTED SERVICE PROVIDED AT AN OFF-CAMPUS, OUTPATIENT, PROVIDER-BASED DEPARTMENT OF A HOSPITAL

Modifier -PN is new in 2017 and is appended to the code for the technical component of non-excepted services and procedures performed in an off-campus provider-based department of a hospital. Non-excepted services include all services except those performed at hospital remote locations, satellite facilities, and emergency departments.

Excepted services are items and services furnished after January 1, 2017:

- **By a dedicated emergency department;**
- **By an off-campus PBD that was billing for covered outpatient provider department (OPD) services furnished prior to November 2, 2015, [i.e., the date of enactment of section 603 of the Bipartisan Budget Act of 2015 (Section 603)] that has not impermissibly relocated or changed ownership;**
- **By an off-campus PBD that qualifies for an exception under section 16001 or 16002 of the 21st Century Cures Act*; or**
- **In a PBD that is "on the campus", or within 250 yards, of the hospital or a remote location of the hospital.**

Payment for services reported with a -PN modifier will result in a new payment methodology for the technical component ~~using the Medicare physician fee schedule~~. The new fee schedule combines some of the bundling concepts of the OPPS with the payment to physicians for procedures performed in a non-facility (office) setting. **The technical component payment when the -PN modifier is appended follows the following logic:**

Payment for Nonexcepted Items and Services by OPPS Status Indicator

OPPS STATUS INDICATOR	ITEM/SERVICE CATEGORY	OPPS PAYMENT PRIOR TO SECTION 603 IMPLEMENTATION	MPFS PAYMENT ADOPTED IN THIS INTERIM FINAL RULE WITH COMMENT PERIOD
A	Ambulance Services	Paid according to Ambulance fee schedule	No change relative to current payment
	Separately payable clinical diagnostic laboratory services	Paid according to CLFS fee schedule	
	Separately payable non- implantable prosthetics and orthotics	Paid according to DMEPOS fee schedule	
	Physical, Occupational, and Speech Therapy	Paid according to MPFS Facility Rate	
B	Codes not recognized by OPPS when submitted on outpatient hospital bill type	Not Applicable	
C	Inpatient Procedures	Not Applicable	
D	Discontinued Codes	Not Applicable	
E1	Not covered by any Medicare outpatient benefit category	Not Applicable	
E2	Medicare covered item; no pricing available	Not Applicable	
F	Corneal tissue acquisition	Paid at reasonable cost	No change relative to current payment
	Certain CRNA services		
	Hepatitis B Vaccines		
G	Pass-through drugs and biologicals	ASP+6%	ASP+6%
H	Pass-through device categories	Amount by which the hospital's charges, adjusted to cost, exceeds the OPPS payment rate associated with the device	No change relative to current payment
J1	Hospital Part B services paid through a comprehensive APC	Claim-level packaged payment	Paid 50 % of C-APC rate
J2	Hospital Part B services that may be paid through a Comprehensive APC (Observation)	Comprehensive APC Payment	Paid 50% of C-APC rate
K	Nonpass-through drugs, biologicals, therapeutic radiopharmaceuticals	ASP+6%	ASP+6%
L	Influenza Vaccine	Paid at reasonable cost	Paid at reasonable cost
	Pneumocccal Pneumonia Vaccine		
M	Items and Services not billable to the MAC	Not Applicable	
N	Items and Services Packaged into APC rates	Payment packaged with procedure	No change relative to current payment
P	Partial hospitalization	Separate APC payment	CMHC Rate
Q1	STV-packaged codes	Packaged APC payment if billed on same claim with "S," "T," or "V" procedure	Paid at 50% of APC rate if billed without "S," "T," or "V" procedure; otherwise packaged

OPPS STATUS INDICATOR	ITEM/SERVICE CATEGORY	OPPS PAYMENT PRIOR TO SECTION 603 IMPLEMENTATION	MPFS PAYMENT ADOPTED IN THIS INTERIM FINAL RULE WITH COMMENT PERIOD
Q2	T-packaged codes	Packaged APC payment if billed on same claim with "T" procedure	Paid at 50% of APC rate if billed without "T" procedure; otherwise packaged
Q3	Codes that may be paid through a composite APC	Composite payment when criteria met; otherwise separate APC payment or packaged payment	Paid at 50% of APC rate if composite criteria met; otherwise packaged
Q4	Conditionally packaged laboratory tests	Conditionally packaged APC payment when billed on same claim with HCPCS codes assigned SI J1, J2, S, T, V, Q1, Q2, or Q3; otherwise paid under clinical laboratory fee schedule	Paid at CLFS rate when billed without primary service; otherwise packaged
R	Blood and blood products	Charges reduced to costs	No change relative to current payment
S	Procedure or Service, Not Discounted when multiple	Separate APC payment	Paid at 50% of APC rate
T	Procedure or Service, Multiple Procedure Reduction Applies	Separate APC payment	Paid at 50% of APC rate Existing MPFS Multiple Procedure Payment Reduction Policies Apply
U	Brachytherapy sources	Charges reduced to costs	No change relative to current payment
V	Clinic Visit	Separate APC payment	Paid at 50% of APC Rate
Y	Non-implantable Durable Medical Equipment	Paid according to DMEPOS fee schedule	No change relative to current payment

The professional component will be paid under the existing physician fee schedule.

MODIFIER PO – SERVICES, PROCEDURES AND/OR SURGERIES PROVIDED AT OFF-CAMPUS PROVIDER-BASED OUTPATIENT DEPARTMENTS

Modifier -PO is appended to the code for the technical component of excepted services and procedures performed in an off-campus provider based department (PBD) of a hospital.

Excepted services are items and services furnished after January 1, 2017:

- By a dedicated emergency department;
- By an off-campus PBD that was billing for covered outpatient provider department (OPD) services furnished prior to November 2, 2015, [i.e., the date of enactment of section 603 of the Bipartisan Budget Act of 2015 (Section 603)] that has not impermissibly relocated or changed ownership;
- By an off-campus PBD that qualifies for an exception under section 16001 or 16002 of the 21st Century Cures Act*; or

- In a PBD that is "on the campus", or within 250 yards, of the hospital or a remote location of the hospital.

In many instances, it will be determined by the date the outpatient department was established.

The -PO modifier is never reported by a dedicated hospital emergency room.

Both the -PO and -PN modifiers would never be reported on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a nonexcepted off-campus PBD of the hospital, the -PO modifier should be used on the excepted claim lines, and the -PN modifier should be used on the non-excepted claim lines.

Page 39, Medically Unlikely Edits

Date of service MUEs are further differentiated as to whether there is the ability to appeal the denial by an MUE Adjudication Indictor (MAI). The MAI is a numerical classification with 2 denoting it cannot be appealed and 3 denoting it can be appealed. If a denial is received for an MAI3 edit and, after further review, the provider determines the units of service were correct, the denial can be appealed. Code 75956, discussed above, is an MAI2 edit. A denial based on the edit cannot be appealed, as it is an initial procedure code that shouldn't be repeated. Code 37252 (IVUS, initial vessel) is an MAI3 edit. If it is denied and the provider determines it should have been reported more than once because the procedure was repeated in a separate session, the denial ~~can~~ **cannot** be appealed.

Page 39, Add-on Code Edits

For example, the footnote to code 37253 (IVUS each additional vessel) states: "(Use 37253 in conjunction with 37252)." If code 37253 is on the claim without code 37252, it will be denied. It cannot be reported without its base code.

Note: In January 2017, many of the add-on code edits for codes 77002 and 77003 are more restrictive than the AMA intended. The AMA is working with CMS to get the edits for these codes expanded.

Page 40, Conscious Sedation

Moderate (Conscious) Sedation

For 2017, the reporting of **moderate (**conscious**)** sedation has changed significantly. Previously, conscious sedation (termed "moderate sedation" in the 2017 *CPT Codebook*) was bundled into many procedure codes by the AMA. In 2017, conscious sedation is no longer bundled ~~by the AMA~~ into procedure codes. New codes have been created, and the bundling of conscious sedation into procedure codes has been discontinued.

Page 40, Coding Instructions

1. Moderate sedation is reported separately whenever performed **and documented appropriately (see the *CPT Codebook* introductory section to codes 99151-99157 for required elements)**.

2. **An "independent trained observer" is required when the physician performing the procedure oversees the moderate sedation. This individual monitors the patient throughout the procedure and should not have other duties that interfere with this responsibility.**

3. The codes are differentiated by age, **as well as** whether **the moderate sedation is provided by** ~~performed by~~ the **same** physician **(or other qualified healthcare professional) who is** performing the procedure or **by someone different** ~~another physician, and initial versus additional time~~. **The codes are also broken down into initial versus additional time.**

4. For a patient under 5 years of age, report code 99151 for the initial 15 minutes of moderate sedation provided by the physician performing the procedure.

5. For a patient 5 years of age or older, report code 99152 for the initial 15 minutes of moderate sedation provided by the physician performing the procedure.

6. Report code 99153 for each additional 15 minutes of moderate sedation provided by the physician performing the procedure, regardless of age. It is reported in addition to code 99151 or 99152 **(for facility billing)**.

7. **Physicians may not bill code 99153 to Medicare when overseeing moderate sedation in a facility (hospital) setting. CMS has designated code 99153 as a technical component only code for physician billing. It may only be reported by the physician when performed in the non-facility (e.g., office, IDTF) setting. In the facility setting, the physician performing the procedure may only report the initial 15-minute code (99151 or 99152) when overseeing moderate sedation.**

8. For a patient under 5 years of age, report code 99155 for the initial 15 minutes of moderate sedation provided by a different physician than the one performing the procedure.

9. For a patient 5 years of age or older, report code 99156 for the initial 15 minutes of moderate sedation provided by a different physician than the one performing the procedure.

10. Report code 99157 for each additional 15 minutes of moderate sedation provided by a different physician than the one performing the procedure, regardless of age. It is reported in addition to code 99155 or 99156.

11. Report initial procedure codes 99151, 99152, 99155, and 99156 only one time per session.

12. Do not report moderate sedation **(99151, 99152, 99155, or 99156)** separately if less than 10 minutes of sedation is performed.

13. Do not report an additional 15 minutes of moderate sedation until a total of 23 minutes of sedation has been performed. The second additional 15-minute charge would be applied after a total of 38 minutes of sedation time. To report an additional 15-minute code, at least 8 additional minutes of sedation must have occurred after achieving the previous 15-minute block of time.

14. When determining **face-to-face** time, the timed sequence begins when the sedating agents are administered and ends when the procedure is completed and the patient is stable for recovery. The physician face-to-face time is the determining factor for reporting time. The documentation must clearly support this direct and continuous physician face-to-face time with the patient during moderate sedation.

15. Do not include pre-procedure activities (i.e., assessment of the patient, explanation of the procedure and informed consent, record review, etc.) when calculating sedation time; the sedation must be administered to begin counting time.

16. Do not include post-procedure activities (i.e., monitoring vital signs, discharging patient, documentation of sedation, family explanation, additional face-to-face time after sedation monitoring has ended, etc.) when calculating sedation time.

17. Do not report the services of patient monitoring separately. Pulse oximetry, rhythm strips, blood pressure monitoring, etc. are included in the moderate sedation codes.

18. Do not report minor sedation (anxiolysis) with the moderate sedation codes. Moderate sedation codes describe a "drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation".

19. For hospitals billing under HOPPS, moderate sedation is reported separately, but Medicare does not reimburse it

separately.

20. ZHealth Publishing recommends the physician document face-to-face time in the report, as well as the drugs utilized, and that an independent trained observer was present during the procedure.

21. The physician should be well versed in the requirements outlined in the *CPT Codebook* section on moderate sedation.

Page 175, Coding Instructions

The following coding instruction is missing its instruction number. It should be listed as coding instruction #20:

20. If imaging is via remote access [catheter placement in brachial artery via femoral approach—36217, 36901-52 (or -74 for hospital billing)], and then a separate access to the graft is performed for intervention (venoplasty), delete code 36901-52 (or -74 for hospital billing) and add the appropriate code(s) for the intervention (36902-36909).

Page 220, Coding Instructions

53. Do not report codes 37211-~~3724~~ **37214** for non-catheter-directed intravenous infusions of heparin, AngioMax, Abciximab (ReoPro), etc.

Page 543, Coding Instructions

6. Do not codes for treatment of post-discography pain (e.g., ~~62310, 62311~~ **62320-62323**) separately. Treatment of post-procedure pain is included in the discography.

Page 551, Coding Instructions

4. Do not report code ~~62311~~ **62320, 62321, 62322, or 62323** for injection of a chemo-therapeutic agent into the sub-arachnoid space. Needle placement and administration of chemotherapy are bundled into code 96450.

Page 621, Code Table

The last column of the Family 02 code table is incorrectly labeled as "APC".

Family 02 - CT and CTA with and without Contrast		
APC 8005 (CT and CTA without Contrast Composite)		
CODE DESCRIPTION	PROC CODE	~~APC~~ TOTAL RVU

Page 646, References

Clinical Examples in Radiology, Spring 17:9-10&14

Page 664, Appendix E

CPT Category III codes can be found on the AMA website at: ~~https://www.download.ama-assn.org/resources/doc/cpt/x-pub/cptcat3codes.pdf~~ **https://www.ama-assn.org/practice-management/cpt-category-iii-codes**. You must have an AMA account to access the file.

Page 699, Charge Sheet

The following code description has been revised:

Transforaminal epidural cervical/thoracic injection, each addtl level **with ultrasound guidance**	☆0229T

Page 700, Charge Sheet

The following procedure codes have the incorrect S&I codes listed with them (codes that are listed correctly in the book have been omitted; only the codes with corrections have been included below):

SPINAL PROCEDURES			
Procedure	**RVU**	**Correct S&I**	**Incorrect S&I**
64400	2.05		~~☆77003~~
64402	2.32		~~☆77003~~
64405	1.81		~~☆77003~~
64408	2.49		~~☆77003~~
64410	2.17		~~☆77003~~
64413	2.33		~~☆77003~~
64415	1.86		~~☆77003~~
64416	2.26		~~☆77003~~
64417	2.01		~~☆77003~~
64418	2.19		~~☆77003~~
64420	1.94		~~☆77003~~
64421	2.63		~~☆77003~~
64425	2.68		~~☆77003~~
64430	2.33		~~☆77003~~
64435	2.38		~~☆77003~~
64445	2.07		~~☆77003~~
64446	2.26		~~☆77003~~
64447	1.90		~~☆77003~~
64448	2.04		~~☆77003~~
64449	2.40		~~☆77003~~
64450	1.30		~~☆77003~~
64505	2.52	**☆77002**	~~☆77003~~
64508	2.06	**☆77002**	~~☆77003~~
64510	2.10	**☆77003**	
64520	2.32	**☆77003**	