

CPT 2024 Anticipated Code Changes

Several Category III codes will be converted to Category I codes in the Current Procedural Terminology (CPT®) 2024 code set, these include: dorsal sacroiliac (SI) arthrodesis; coronary fractional flow reserve (FFR) with computerized tomography (CT); coronary intravascular lithotripsy (IVL) interventions; transcervical radiofrequency ablation (RFA) of uterine fibroids; and cardiac intraoperative ultrasound services (IOUS). This article provides an overview of the anticipated changes in 2024.

Revisions will be made within several subsections of the evaluation and management (E/M) section to standardize the rest of the E/M sections of the CPT code set in an effort to decrease providers' administrative burden of documentation as outlined in the Medicare's 2023 Final Rule. In addition, a new E/M subsection with new guidelines for split or shared services will be created. The new codes will be structured to align with the current E/M office or other outpatient services code structure.

Additionally, there will be revisions to the reporting guidelines for unlisted service codes for various sections of the CPT 2024 code set to reflect appropriate use of unlisted codes when reporting with other services.

The ACR urges its members to review and consider how the new code changes may impact their practices.

CPT 2024 CODE SET: NEW CATEGORY I CODES

New Category I codes will be available January 1, 2024, and are summarized below.

Transcervical RFA of Uterine Fibroids

Transcervical RFA of uterine fibroids includes intraoperative ultrasound guidance and monitoring, a minimally invasive procedure that includes real-time intrauterine ultrasound guidance for the treatment of symptomatic uterine fibroids (ie, leiomyomas) will be converted from Category III code 0404T to a new Category I code.

Dorsal SI Joint Arthrodesis

Category III code 0775T will be converted to a Category I code to report percutaneous arthrodesis of the SI joint using an intra-articular implant(s) without the placement of a transfixation device across the joint. The new Category I code will enable the reporting of percutaneous intra-articular placement of one or more fusion implants directly into the SI joint under imaging guidance. This is usually performed from a posterior approach.

In contrast, existing code 27279 is used to report percutaneous placement of a transfixation device, such as a screw, across the SI joint to perform fusion. This is usually performed from a lateral approach.

Coronary FFR with CT

Coronary FFR with CT Codes 0501T-0504T will be converted to a single, new Category I code to report non-invasive estimated coronary FFR derived from augmentative artificial intelligence (AI) software analysis of coronary CT angiography (CCTA) data.

Coronary IVL Interventions

Coronary IVL is a revascularization technique used to treat heavily calcified coronary arteries using pulsatile sonic pressure waves that pass through soft tissue and selectively interact with high-density calcium to produce shear stresses that fracture the calcium.

A new Category I add-on code will replace Category III code 0715T to report percutaneous transluminal coronary lithotripsy.

Cardiac IOUS

Cardiac IOUS are used to evaluate cardiovascular structures, provide intraoperative guidance, and provide real-time perioperative surgical decision-making information that may affect the intraoperative strategy (eg, changing cannulation strategies, altering bypass targets, and identifying additional defects).

Four new Category I codes will be available to report cardiac IOUS, which are used primarily in cardiothoracic surgery procedures, including epiaortic ultrasound and congenital epicardial echocardiography.

REVISIONS TO E/M CODES

Additional revisions will be made to the E/M codes in 2024 as part of the work of the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) to decrease the administrative burden of documentation outlined in Medicare's 2023 Final Rule.

The following updates will include:

- Time ranges will be removed from the office or other outpatient visit codes for codes 99202-99205 and 99212-99215 to align with the format of other E/M codes.
- The portion of physician's services that may be reported for split (or shared) visits will be defined.
- Reporting instructions will be added for codes 99234-99236 [(hospital inpatient or observation care services) (including admission and discharge services)] when the duration of the visit crosses over two calendar dates.

Telemedicine Office Visits

A CPT/RUC Telemedicine Office Workgroup was created to assess and develop appropriate coding guidance for E/M telemedicine office visits performed via audio-visual and audio-only mechanisms.

The workgroup determined that a new E/M subsection with new guidelines for telemedicine services will be established in the CPT 2024 code set.

The new codes will align with the current E/M office or other outpatient services code structure (ie, using time or medical decision making [MDM]) with separate codes for new and established patient encounters and the addition of a virtual check-in code that could be used to determine whether a patient needs a face-to-face visit. Codes 99441, 99442, and 99443 will be deleted.

Reporting Guidelines for Unlisted Codes

In 2024, revisions will be made to various sections of the CPT code set that contain unlisted service codes to reflect their appropriate use when reporting with other services.

An unlisted code workgroup was established by the CPT Editorial Panel to evaluate the use of unlisted service codes. The workgroup addressed how unlisted codes are used in conjunction with existing Category I and III codes during the same intervention and whether there is a need for guidance on their appropriate use.

REVISED CODES

The following E/M codes will be revised in the CPT 2024 code set:

- 99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter
- 99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter
- 99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter
- 99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter
- 99212** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter
- 99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical

decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter

99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded

DELETED CODES

The codes below will be deleted from the CPT 2024 code set:

99441 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99442 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

99443 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

0404T Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency

- 0501T** Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report
- 0502T** Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission
- 0503T** Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model
- 0504T** Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report
- 0715T** Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)
- 0775T** Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s])