



2016 CPT Update

by Monica Leisch, RHIA, CDIP, CCS

Current Procedural Terminology (CPT) codes are maintained by the American Medical Association (AMA) and are updated quarterly. The main update is done January 1.

Per the AMA, the CPT code changes for 2016 include:

363 new codes

- 140 new codes
- 132 revised codes
- 91 deleted codes

CPT codes are mandated by HIPAA as of 2003 to be the code set used for outpatient and pro fee coding.

This article will address those codes more commonly used by coding professionals in the hospital and outpatient settings, and will apply to all patient care settings unless otherwise specified. The laboratory and radiology code changes will not be addressed here.

Evaluation and Management

The Preventive Services Guidelines have been updated to allow separate reporting for risk management services codes 99381-99397-Preventive Medicine Services. Individual preventive medicine counseling codes 99401-99404 are used to report counseling services in areas such as family problems, diet, and exercise. Individual behavioral change codes 99406-99409 are used to report intervention services for patients with a behavior typically regarded as an illness, such as smoking or obesity. Group counseling and other preventive medicine services are reported with

codes 99411-99412. These codes can now be used along with preventive medicine codes.

The Prolonged Service with Direct Patient Contact section is revised to include a new subsection for prolonged clinical staff services with physician or other qualified health care professional supervision. In addition, two new codes 99415 and 99416 are added with a new parenthetical to report prolonged clinical observation services in the outpatient or office setting. These codes are reported in addition to the code for outpatient evaluation and management service and are used when other qualified health care professionals provide service beyond the usual E/M service. Previously, codes 99354 and 99355 were the only codes available to report these services.

Code 99415 should be used only once per date of service, even if the time spent by the clinical staff is not continuous on that date. Do not report prolonged service of less than 45 minutes total duration on a given date, because the clinical staff time involved is included in the E/M codes. The typical face-to-face time of the primary service is used in defining when prolonged services time begins. For example, prolonged clinical staff services for 99214 begin after 25 minutes; 99415 is not reported until at least 70 minutes total face-to-face clinical staff time has been performed. When face-to-face time is noncontiguous, use only the face-to-

face time provided to the patient by the clinical staff.

Code 99416 is used to report each additional 30 minutes of prolonged clinical staff service beyond the first hour. This code may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately and codes 99415 and 99416 may be reported for no more than two simultaneous patients. It is inappropriate for facilities to report 99415 and 99416.

New Category III Code

0403T- Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes per day. It is used to report the services provided in a standardized diabetes prevention program (DPP) recognized by the CDC.

SURGERY GUIDELINES

Editorial Change - Imaging Guidance

When imaging guidance or imaging supervision and interpretation is included in a surgical procedure, guidelines for image documentation and report included in the guidelines for radiology (including nuclear medicine and diagnostic ultrasound) will apply.

Integumentary System - Two New Codes

10035- Placement of soft tissue localization device(s) (e.g. clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion.

10036- Each additional lesion (list separately in addition to code for primary procedure).

New Category III Codes

0400T- Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia; one to five lesions.

0401T- Six or more lesions.

These new codes allow for multi-spectral digital skin lesion analysis to help dermatologists decide which lesions may be suspicious for melanoma and provide information about the structure of a lesion from under the skin.

MUSCULOSKELETAL SYSTEM**Knee Replacement Arthroplasty – New Category III Code**

+0396T- Intra-operative use of kinetic balance sensor for implant stability during knee replacement arthroplasty. This code allows for the procedure to detect misalignments during a total knee arthroplasty (TKA). Many suboptimal outcomes are believed to be the result of poor component alignment and soft tissue balancing during TKA.

RESPIRATORY SYSTEM**Bronchoscopy with EUBS – Three New Codes**

31652 - Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration(s)/biopsy(ies), one or two mediastinal and/or hilar lymph node stations or structures.

31653 - Three or more mediastinal and/or hilar lymph node stations or structures.

+31654 - With transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic, diagnostic or therapeutic intervention(s) for peripheral lesion(s).

Nasal Endoscopy – Two New Category III Codes

0406T - Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant.

0407T - With biopsy, polypectomy or debridement.

Implantable drug-eluting sinus devices provide an option for postoperative management following FESS and other sinus procedures. The implants are inserted under endoscopic guidance to stabilize the sinus openings and the turbinates, reduce edema, and/or prevent obstruction by adhesions. They also deliver medications (e.g. steroids) topically over an extended period of time (e.g. 30 days).

CARDIOVASCULAR SYSTEM**Transcatheter Valve Replacement – New Code**

33477 - Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site when performed.

Intravascular Ultrasound (IVUS) – New Codes

+37252 - Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial non-coronary vessel.

+37253 - Each additional non-coronary vessel.

For Monitoring – New Category III Codes

0381T - External heart rate and 3-axis accelerometer data recording up to 14 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report, review and interpretation by a physician or other qualified health care professional.

0382T - Review and interpretation only.

0383T - External heart rate and 3-axis accelerometer data recording from 15 to 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report, review and interpretation by a physician or other qualified health care professional.

0384T - Review and interpretation only.

0385T - External heart rate and 3-axis accelerometer data recording more than 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events; includes report, scanning analysis with report, review and interpretation by a physician or other qualified health care professional.

0386T - Review and interpretation only.

Pacemaker – Leadless and Pocketless System is a pulse generator with built-in battery and electrode for implantation in a cardiac chamber via a transfemoral catheter approach.

0387T - Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular.

0388T - Transcatheter removal of permanent leadless pacemaker, ventricular.

Programming and Evaluation – New Codes

0389T - Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report, leadless pacemaker system.

0390T - Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure or test with analysis, review and report, leadless pacemaker system.

0391T - Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system.

MEDIASTINUM AND DIAPHRAM

Mediastinoscopy detects problems of the lungs and mediastinum, such as sarcoidosis, lung cancer or lymphoma. Mediastinoscopy is often done to check lymph nodes in the

mediastinum before considering lung removal surgery to treat lung cancer. It can recommend the best treatment (surgery, radiation, chemotherapy) for lung cancer. Other diagnosis, such as certain types of infection, especially those that can affect the lungs (e.g. tuberculosis) can also be found.

New Codes

39401 - Mediastinoscopy; includes biopsy(ies) of mediastinal mass (e.g. lymphoma) when performed.

39402 - Mediastinoscopy; with lymph node biopsy(ies) (e.g. lung cancer staging).

39400 - Has been deleted.

DIGESTIVE SYSTEM

New comprehensive codes in the biliary section were introduced for percutaneous transhepatic cholangiograms, as well as biliary drainage catheter placement, revision/conversion, replacement, and removal. Another important change shows several new codes are now available when previously they were only reportable with the biliary endoscopic codes. These include several new codes for biliary dilatation, stenting, and biopsy.

Cholangiography-Injection Procedures – New Codes

47531 - Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (e.g. ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access.

47532 - New access (e.g. percutaneous transhepatic cholangiogram).

47500 and **74320** - Have been deleted.

Biliary Drainage Catheter – New Codes

47533 - Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g. ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; external.

47534 - Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g. ultrasound and/or fluoroscopy), and all associated radiological supervision and Biliary Drainage Catheter.

47535 - Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g. fluoroscopy), and all associated radiological supervision and interpretation.

47536 - Exchange of biliary drainage catheter (e.g. external, internal-external, or conversion of internal/-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g.

fluoroscopy), and all associated radiological supervision and interpretation

47537 - Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (e.g. with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg. fluoroscopy), and all associated radiological supervision and interpretation.

47538 - Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (e.g. fluoroscopy and/or ultrasound), balloon dilation, catheter exchange or removal when performed, and all associated radiological supervision and interpretation, each stent; existing access.

47539 - Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg. fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation, each stent; new access, without placement of separate biliary drainage catheter.

47540 - Each stent; new access, with placement of separate biliary drainage catheter (e.g. external or internal-external).

Biliary Access – New Code

47541 - Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (e.g. rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g. ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access.

Biliary Balloon Dilation – New Code

+47542 - Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (e.g. fluoroscopy), and all associated radiological supervision and interpretation, each duct. List separately in addition to code for primary procedure: 47531, 47532, 47533, 47534, 47535, 47536, 47537, 47541. This code includes moderate (conscious) sedation.

Biliary Biopsy – New Code

+47543 - Endoluminal biopsy(ies) of biliary tree, percutaneous, and method(s) (e.g. brush, forceps, and/or needle), including imaging guidance (e.g. fluoroscopy), and all associated radiological supervision and interpretation, single or multiple. List separately in addition to code for primary procedure: 47531, 47532, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540. It includes moderate (conscious) sedation.

Biliary Stones/Debris Removal – New Code

+47544 - Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi

by method (e.g. mechanical, electrohydraulic lithotripsy) when performed, imaging guidance (e.g. fluoroscopy), and all associated radiological supervision and interpretation. List separately in addition to code for primary procedure: 47531, 47532, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540. The codes include moderate (conscious) sedation.

Sclerotherapy – New Code

49185 - Sclerotherapy of a fluid collection (e.g. lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (e.g. ultrasound, fluoroscopy) and radiological supervision and interpretation when performed. This code is used when interconnected lesions treated through a single access and then is reported only once. It is appropriate to use modifier 59 for each additional treated lesion.

New Category III Codes

0392T - Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e. magnetic band) [LINX].

0393T - Removal of esophageal sphincter augmentation device.

+0397T - ERCP with optical endomicroscopy (OE) (report in conjunction with cat I ERCP codes).

Extracorporeal Liver Assist System

0405T - Oversight of the care of an extracorporeal liver assist system patient requiring review of status, review of laboratories and other studies, and revision of orders and liver assist care plan (as appropriate), within a calendar month, 30 minutes or more of non-face-to-face time. This code is used to aid a compromised or failing liver. Devices that support liver function outside of the body are Liver dialysis and Bioartificial liver devices.

Urinary System

New comprehensive codes were created for nephrostogram and nephrostomy procedures and ureteral stents. The new codes bundle the radiologic supervision and interpretation. 74475 and 74480 S&I codes have been deleted. Many genitourinary codes will remain and will continue to be reported with supervision and interpretation codes. Three new codes have been developed for previously unlisted procedures, ureteral dilation, ureteral embolization, and brush biopsy. 50392, 50393 and 50398 have been deleted along with the S&I codes.

Nephrostogram and Ureterogram – New Codes

50430 - Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (e.g. ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access.

50431 - Existing access (50394 has been deleted).

50432 - Placement of nephrostomy catheter, percutaneous,

including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g. ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation.

50433 - Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g. ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access.

50434 - Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g. ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract.

50435 - Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g. ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation.

New Biopsy Add-on Code

+50606 - Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (e.g. ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation. List separately in addition to code for primary procedure.

Ureteral Stent – New Codes

50693 - Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g. ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract.

50694 - New access, without separate nephrostomy catheter.

50695 - New access, with separate nephrostomy catheter.

Ureteral Embolization Add-on Code

+50705 - Ureteral embolization or occlusion, including imaging guidance (e.g. ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation. List separately in addition to code for primary procedure.

Ureteral Stricture Add-on Code

+50706 - Balloon dilation, ureteral stricture, including imaging guidance (e.g. ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation. List separately in addition to code for primary procedure.

NERVOUS SYSTEM

Endovascular Therapy

Several new therapies for stroke have been developed which involve threading a catheter through the femoral artery to the affected artery in the brain. The stroke is then treated either by injecting thrombolytic medications directly into the

affected artery or by removing a clot mechanically with or without placing a stent. Codes 37184, +37185 and +37186 have been revised to differentiate “non-intracranial”. Code 75896 has been deleted.

New Codes

61645 - Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s).

61650 - Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory.

+61651 - Each additional vascular territory.

Paravertebral Blocks - New Codes

64461 - Paravertebral block (PVB) (paraspinous block), thoracic; single injection (includes imaging guidance, when performed).

64462 - Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure).

64463 - Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed).

The new CPT codes were developed to differentiate the paravertebral block from the transforaminal epidural (Code 64479-64484), which are used to treat back pain. Deleted code 64412- Injection, anesthetic agent; spinal accessory nerve are replaced with unlisted code 64999.

EYE AND OCULAR ADNEXA

Corneal Procedures – New Code

65785 - Implantation of intrastromal corneal ring segments. This procedure alters the curvature of the cornea. It is performed for conditions like keratoconus. 0099T is deleted. The rings split into two arcs that simplifies the insertion procedure and minimizes the complications. They are available in different thickness and diameters, depending on the degree of correction required.

New Category III Code

0402T - Collagen cross-linking of cornea (including removal of the corneal epithelium and intraoperative pachymetry when performed. Corneal cross-linking (CXL) is an in-office eye procedure that strengthens the cornea if it's been weakened by keratoconus, other corneal disease, or (rarely) a complication of LASIK surgery. It is a minimally invasive procedures involves the application of liquid riboflavin (vitamin B2) to the surface of the eye, followed by treatment with a controlled application of ultraviolet light, to eliminate corneal ectasia.

Retina or Choroid Procedures – Revised Codes

67101, 67105, 67107, 67108 and **67113** have been revised. Terminology “with or without” has been changed to “when performed”.

67101 - Repair of retinal detachment, 1 or more sessions; cryotherapy or diathermy, including drainage of subretinal fluid, when performed.

67105 - Repair of retinal detachment, 1 or more sessions; photocoagulation, including drainage of subretinal fluid, when performed.

67107 - Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid .

67108 - Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique.

67113 - Repair of complex retinal detachment (e.g. proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens. 67112 has been deleted.

67227 and 67228 have been revised to remove “1 or more sessions” and now read as follows:

67227 - Destruction of extensive or progressive retinopathy (e.g. diabetic retinopathy), cryotherapy, diathermy.

67228 - Treatment of extensive or progressive retinopathy (e.g. diabetic retinopathy), photocoagulation.

AUDITORY SYSTEM

Removal impacted Cerumen – New Code

69209 - Removal impacted cerumen using irrigation/lavage, unilateral. The other code 69210 will continue to be used when the impacted cerumen is removed using instrumentation. Do not report 69209 in conjunction with 69210 when performed on the same ear. For bilateral procedure, report 69209 with modifier 50. For cerumen removal that is not impacted, see E/M service code.

MEDICINE

In this section, nearly all of the vaccine codes (90476-90749) have been updated to include the Advisory Committee on Immunization Practices (ACIP) abbreviations for the vaccine products (e.g. diphtheria, tetanus toxoids, acellular pertussis = DTaP). Codes representing obsolete vaccine products have been deleted. Four new codes have been added.

Notations will be kept in CPT for the next 3 years to remind

users of deleted codes. Most of the deleted codes are for individual vaccines that are now included in a combination vaccine.

Deleted Vaccine Codes

90645 - Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule).

90646 - Hemophilus influenza b vaccine (Hib), PRP-D conjugate, booster.

90669 - Pneumococcal conjugate vaccine, 7 valent (PCV7).

90692 - Typhoid vaccine, heat- and phenol-inactivated (H-P).

90693 - Typhoid vaccine, acetone-killed, dried (AKD).

90720 - Diphtheria, tetanus toxoids, and whole cell prussic vaccine and Hib vaccine (DTwP-Hib).

90721 - Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Haemophilus influenzae b vaccine (DTaP/Hib).

90725 - Cholera vaccine.

90727 - Plague vaccine.

90735 - Japanese encephalitis virus vaccine.

New Vaccine Codes

90620 - Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule, for intramuscular use.

90621 - Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for intramuscular use.

90625 - Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use.

90697 - Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
Hexavalent code: Vaccine for six diseases combined into single vaccine.

Caloric Vestibular Testing - Used to evaluate the vestibular nerve.

New Codes

92537 - Caloric vestibular test with recording, bilateral; bithermal (i.e. one warm and one cool irrigation in each ear for a total of four irrigations). Do not report 92537 in conjunction with 92270, 92538.

92538 - Monothermal (i.e. one irrigation in each ear for a total of two irrigations). Do not report 92538 in conjunction with 92270, 92537, 92537 and 92538 are bilateral code for unilateral irrigation; use modifier 52 for pro fee reporting. This code replaces CPT code 92543 (Caloric vestibular test, each irrigation, with recording).

Deletions

0240T - High resolution esophageal manometry. Use 91010 - Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report to report instead.

0241T - High resolution esophageal manometry with stimulation/perfusion. Use 91013 - Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion (e.g. stimulant, acid or alkali perfusion) instead.

Reflectance Confocal Microscopy (RCM) – New Codes

New imaging for noninvasive real-time tissue imaging with high resolution and contrast comparable with conventional histology.

96931 - Reflectance confocal microscopy for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion.

96932 - Image acquisition only, first lesion.

96933 - Interpretation and report only, first lesion.

+96934 - Image acquisition and interpretation and report, each additional lesion.

+96935 - Image acquisition only, each additional lesion.

+96936 - Interpretation and report only, each additional lesion.

This technology allows a virtual imaging into living skin without the need for a conventional biopsy.

Ocular Screening

Revised Code 99174 - Instrument based ocular screening (e.g. photoscreening, automated-refraction), bilateral; with remote analysis and report. Do not report 99174 in conjunction with 92002-92014, 99172, 99173, 99177.

New Code 99177 - With on-site analysis. Do not report 99177 in conjunction with 92002-92014, 99172, 99173, 99174.

An automated refraction system is a group of ophthalmic devices used during an eye examination to aid in the determination of a person's refractive error and prescription for glasses or contact lenses.

References

CPT Changes 2016: An Insider's View (2016). Chicago, IL: American Medical Association