Familiarizing Yourself with CPT Coding Updates for 2020

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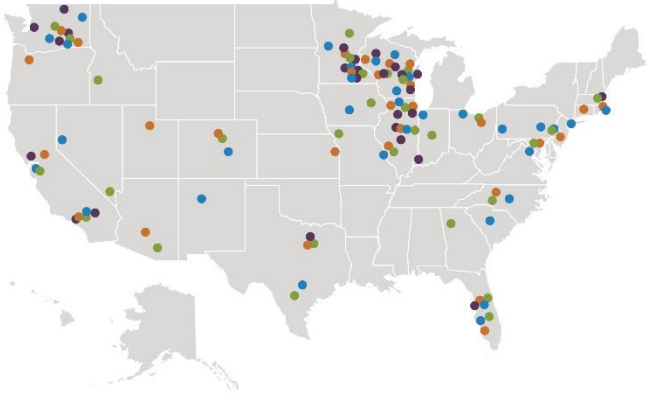

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Learning Objectives

- At the end of this session, you will be able to:
  - Understand the CMS revised E/M guidance effective January 1, 2020, the anticipated changes for 2021, and how your organization can prepare for these changes.
  - Explain the radiology code changes for 2020 with SPECT codes, bundling of Gastrointestinal (GI) codes, and others.
  - Discuss the deletions and additions to the electroencephalography codes (EEG).
  - Identify new codes and changes to existing codes in the health and behavioral assessments.
  - Discuss digital communication tools, e-visits, and home-based services for patients.

Speaker Introductions

Sandy Giangreco Brown

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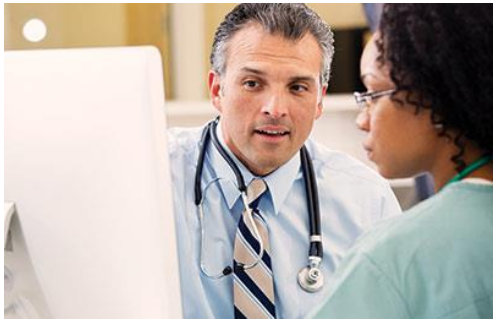
Sandy is the Director of Coding and Revenue Integrity. She is an AHIMA Approved ICD-10-CM/PCS trainer specializing in physician practices and outpatient hospitals and also has experience in the HIM, Chargemaster and the inpatient hospital side of business. She has more than 30 years of experience in health care and medical records management, coding, auditing, and compliance in the hospital, outpatient, and physician settings.

CPT Update

Section	New	Revised	Deleted
Evaluation and Management	6	1	1
Anesthesia	0	0	0
Surgery	38	37	17
Radiology	12	18	15
Pathology and Laboratory	14	4	0
Medicine	47	10	21
Category II	5	3	1
Category III	51	1	11
Proprietary Laboratory Analyses	75	1	5
Total	**248**	**75**	**71**

New Guidance



- Modifier 50 not to be used on add-on codes – use # units instead

Example:

Paravertebral facet joint injections bilaterally at L2-3 and L3-4

64493-50 – Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

64494 x 2 – Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level

Online Digital Evaluation and Management Services

- #99421 – Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- #99422 – 11-20 minutes
- #99423 – 21 or more minutes

Patient-initiated digital communications requiring a clinical decision that would otherwise be made during an office visit

- Physician/Qualified Healthcare Professional (QHP) time only
- Not billable if patient seen in person or through telehealth within 7 day period

Remote Physiologic Monitoring

- #99457 Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

#+99458 – each additional 20 minutes

Online Digital – Services

Similar codes for nonphysician professionals, but CMS prefers the term “assessment”

- 98970 – Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- 98971 – 11-20 minutes
- 98972 – 21 or more minutes

- G2061 – Qualified nonphysician health care professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes
- G2062 – Qualified nonphysician health care professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes
- G2063 – Qualified nonphysician health care professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes

Self-Measured Blood Pressure

- #99473 – Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
- #99474 – separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

Revisions to Repair Guidelines

Definitions of limited versus extensive undermining to distinguish between intermediate and complex repair

- Limited undermining – distance less than the maximum width of the defect, measured perpendicular to the closure line, along at least one entire edge of the defect
- Extensive undermining – a distance greater than or equal to the maximum width of the defect, measured perpendicular to the closure line along at least one entire edge of the defect

Complex Repair

Requires at least one of the following:

- exposure of bone, cartilage, tendon, or named neurovascular structure
- debridement of wound edges (eg, traumatic lacerations or avulsions)
- extensive undermining
- involvement of free margins of helical rim, vermilion border, or nostril rim
- placement of retention sutures

Scar revision is not automatically considered a complex repair

Tissue Grafting

- #15769 – Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
- 15771 – Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs;
- +15772 – each additional 50 cc injectate, or part thereof
- 15773 – Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
- +15774 – each additional 25 cc injectate, or part thereof

Breast

- Clarification that mastectomy codes, other than for gynecomastia are to treat or prevent cancer
- Removal of tissue for size reduction is to be coded 19318, reduction mammoplasty (unless for gynecomastia)
- 19304 for subcutaneous mastectomy deleted
- Codes for excision of chest wall tumor relocated to Musculoskeletal System

Chest Wall Tumors

- 21601 – Excision of chest wall tumor including rib(s)

  previously 19260
- 21602 – Excision of chest wall tumor involving rib(s), with plastic reconstruction; without mediastinal lymphadenectomy

  previously 19271
- 21603 – with mediastinal lymphadenectomy

  previously 19272

“Dry Needling”

- #20560 – Needle insertion(s) without injection(s); 1 or 2 muscle(s)
- #20561 – 3 or more muscles

Drug Delivery Devices

Used in orthopedic surgery – distinguished from 11981-11983

- +20700 – Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial)
- +20701 – Removal of drug delivery device, deep
- +20702 – Manual preparation and insertion of drug-delivery device(s), intramedullary
- +20703 – Removal of drug-delivery device(s), intramedullary
- +20704 – Manual preparation and insertion of drug-delivery device(s), intra-articular
- +20705 – Removal of drug-delivery device(s), intra-articular

Not for prefabricated “off the shelf” devices

If the device is removed with no other procedure performed, code 20680

Pericardiocentesis

- 33016 – Pericardiocentesis, including imaging guidance, when performed
- 33017 – Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly
- 33018 – birth through 5 years of age or any age with congenital cardiac anomaly
- 33019 – Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance

Aortic Arch

- 33858 – Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection
- 33859 – for aortic disease other than dissection (eg, aneurysm)
- 33871 – Transverse aortic arch graft, with cardiopulmonary bypass, with profound hypothermia, total circulatory arrest and isolated cerebral perfusion with reimplantation of arch vessel(s) (eg, island pedicle or individual arch vessel reimplantation)

Iliac Branched Endograft

- #+34717 – Endovascular repair of iliac artery at the time of aortoiliac artery endograft placement by deployment of an iliac branched endograft including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for rupture or other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer, traumatic disruption), unilateral

Iliac Branched Endograft

- #34718 – Endovascular repair of iliac artery, not associated with placement of an aorto-iliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer), unilateral

Exploration of Artery

▲35701 – Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery neck (eg, carotid, subclavian)

- 35702 – upper extremity (eg, axillary, brachial, radial, ulnar)
- 35703 – lower extremity (eg, common femoral, deep femoral, superficial femoral, popliteal, tibial, peroneal)

Transanal Hemorrhoidal Dearterialization

- 46948 – Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed

Preperitoneal Pelvic Packing

- 49013 – Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration
- 49014 – Re-exploration of pelvic wound with removal of preperitoneal pelvic packing, including repacking, when performed

Orchiopexy – Revision

▲54640 – Orchiopexy, inguinal approach, with or without hernia repair scrotal approach

Clarification that associated hernia repair may be coded separately

Lumbar Puncture

Bundling of codes with fluoro or CT guidance

△ 62270 – Spinal puncture, lumbar, diagnostic;

- #62328 – with fluoroscopic or CT guidance

△ 62272 – Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);

- #62329 – with fluoroscopic or CT guidance

If ultrasound or MRI guidance, code 76942, 77021

Somatic Nerve Injections

Revision of Nerve Injection Codes – once per nerve, regardless of the number of injections

Imaging guidance reported separately except for 64451 and 64454

Table, CPT Professional, page 437

- 64451 – nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
- 64454 – genicular nerve branches, including imaging guidance, when performed

Destruction of Nerves

- #64624 – Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed

- #64625 – Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

Cyclophotocoagulation

▲66711 – cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens

▲66982 – Extracapsular cataract removal with insertion of intraocular lens prosthesis (1stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation

- #66987 – with endoscopic cyclophotocoagulation

▲66984 – Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation

- #66988 – with endoscopic cyclophotocoagulation

Upper GI Studies

74220 – Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study

- 74221 – double-contrast (eg, high-density barium and effervescent agent) study
- +74248 Radiologic small intestine follow-through study, including multiple serial images

Revised descriptions for other upper and lower GI codes

Myocardial PET

- 78459 Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;
  - #78429 – with concurrently acquired computed tomography transmission scan
- 78491 – Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)
  - #78430 – single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
- 78492 – multiple studies at rest and/ stress (exercise or pharmacologic)
  - #78431 – multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan

Myocardial PET

- #78432 – Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);
- #78433 – with concurrently acquired computed tomography transmission scan
- #+78434 – Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress

SPECT-CT

Existing codes revised to specify “planar” – Codes for specific body areas deleted

78800 – Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed);

#78830 – tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging

#78831 – tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days

#78832 – tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/ detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days

#+78835 – Radiopharmaceutical quantification measurement(s) single area

Therapeutic Drug Assays

- 80145 – Adalimumab (eg, Humera®)
- #80230 – Infliximab (eg, Remicade ®)
- #80280 – Vedolizumab (eg, Entyvio®)
- 80187 – Posaconazole (eg, Noxafil®, Posanol®)
- #80285 – Voriconazole (eg, Vtend®)
- #80235 – Lacosamide (eg, Vimpat®)

Pathology and Laboratory

Molecular Pathology – changes from Tier 2 to Tier 1 and vice-versa

New MAAA codes –

- #81522 – Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin embedded tissue, algorithm reported as recurrence risk score
- 81542 – Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score
- 81552 – Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis

Microbiology

- 87563 – Mycoplasma genitalium, amplified probe technique

Proprietary Laboratory Analyses

Not required to fulfill the Category I criteria.

- The test must be commercially available in the United States for use on human specimens
- The clinical laboratory or manufacturer that offers the test must request the code

- PLA codes take precedence over other CPT codes.

Part of the Protecting Access to Medicare Act of 2014

Vaccines

- #  90694 – Influenza virus vaccine, quadrivalent (aIIV4),inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use

- #  90619 – Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use

Biofeedback Training

- 90912 – Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient
- +90913 – each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient

Ophthalmoscopy

- 92201 – Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral
- 92202 – with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral

Computerized Dynamic Posturography

△ 92548 – Computerized dynamic posturography sensory organization test (CDPSOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report;

- +92549 – with motor control test (MCT) and adaptation test (ADT)

Auditory Function Evaluation

- 92626 – Evaluation of auditory rehabilitation function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour
- +92627 – each additional 15 minutes

Myocardial Strain Imaging

- +#93356 – Myocardial strain imaging using speckle tracking–derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)

Arteriovenous Fistula Mapping/Preparation

- 93985 – Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study
- 93986 – complete unilateral study

  Previously G0365

Long-Term EEG Monitoring

Separation of Professional versus Technical Services
Qualifications and Duties for EEG Technologist specified
Definitions of Monitoring: Continuous, Intermittent

Table – CPT Professional, page 715

- #95700 – Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels

Long-Term EEG Monitoring – Professional

10 New Professional Component Codes		
with video	duration/time of report	without video
95718	2-12 hours/daily report	95717
95720	>12-26 hours/daily report	95719
95722	36-60 hours/one report at end	95721
95724	>60-84 hours/one report at end	95723
95726	>84 hours/one report at end	95725

Long-Term EEG Monitoring – Technical Services

12 New Technical Services Codes		
with video	duration/intensity of monitoring	without video
	2 - 12 hours	
95711	unmonitored	95705
95712	intermittent	95706
95713	continuous real-time	95707
	>12 - 26 hours	
95714	unmonitored	95708
95715	intermittent	95709
95716	continuous real-time	95710

Health Behavior Assessment and Intervention

- 96156 – Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
- 96158 – Health behavior intervention, individual, face-to-face; initial 30 minutes
- +96159 – each additional 15 minutes
- 96164 – Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
- +96165 – each additional 15 minutes

Health Behavior Assessment and Intervention

- 96167 – Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
- +96168 – each additional 15 minutes
- 96170 – Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
- #+96171 – each additional 15 minutes

Cognitive Function Intervention

- 97129 – Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks)direct (one-on-one) patient contact; initial 15 minutes
- +97130 – each additional 15 minutes

Category III – Transapical Mitral Valve Repair

- 0543T – Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae

Limited thoracotomy

4-6 “strings” to tighten the

Mitral valve

Category III – Annulus Reconstruction

- 0544T – Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture
- 0545T – Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach

- 0569T – Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis
- +0570T – each additional prosthesis during same session

Category III

- 0547T – Bone material quality testing by microindentation(s) of the tibia(s), with results reported as a score

- 0565T – Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation
- 0566T – injection of cellular implant into knee joint including ultrasound guidance, unilateral

Category III

- 0546T – Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report

- 0581T – Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral

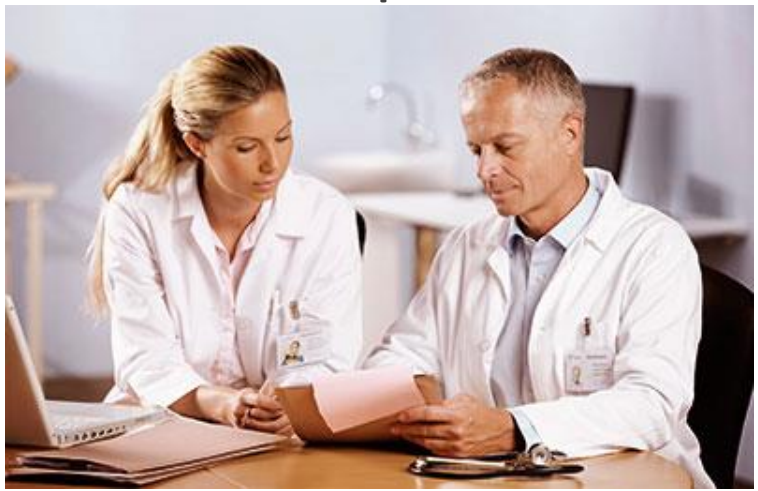
- 0583T – Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia

Category III – Continence Device Procedures

- 0548T – Transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy
- 0549T – unilateral placement, including cystoscopy and fluoroscopy
- 0550T – removal, each balloon
- 0551T – adjustment of balloon(s) fluid volume

Category III – Low-Level Laser Therapy

- 0552T – Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional.



Category III – Evacuation of Meibomian Glands

- #0563T – Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral

Category III – Ablation of Prostate Tissue

- 0582T – Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance

Category III – Posterior Tibial Nerve Stimulation

- 0587T – Percutaneous implantation or replacement of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve
- 0588T – Revision or removal of integrated single device neurostimulation system including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve
- 0589T – Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters
- 0590T – 4 or more parameters

Category III – Islet Cell Transplantation

- 0584T – Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous
- 0585T – laparoscopic
- 0586T – open

Category III – Iliac AV Anastomosis

- 0553T – Percutaneous transcatheter placement of iliac arteriovenous anastomosis implant, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention

Category III – Substernal ICD

- 0571T – Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s),including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters),when performed
- 0572T – Insertion of substernal implantable defibrillator electrode
- 0573T – Removal of substernal implantable defibrillator electrode
- 0574T – Repositioning of previously implanted substernal implantable defibrillator pacing electrode
- 0580T – Removal of substernal implantable defibrillator pulse generator only

Category III – Substernal ICD

- 0575T – Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, 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 by a physician or other qualified health care professional
- 0576T – Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter
- 0578T – Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
- 0579T – Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

Category III – Health Coaching

- 0591T – Health and well-being coaching face-to-face; individual, initial assessment
- 0592T – individual, follow-up session, at least 30 minutes
- 0593T – group (2 or more individuals), at least 30 minutes

Category III – Biomechanical CT

- 0554T – Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone-mineral density, interpretation and report
- 0555T – retrieval and transmission of the scan data
- 0556T – assessment of bone strength and fracture risk and bone-mineral density
- 0557T – interpretation and report
- 0558T – Computed tomography scan taken for the purpose of biomechanical computed tomography analysis

Category III – Anatomic Modeling and Guides

- 0559T – Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure
  - +0560T – each additional individually prepared and processed component of an anatomic structure
- 0561T – Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide
  - +0562T – each additional anatomic guide

Category III – Transcervical Fallopian Tube Occlusion

- 0567T – Permanent fallopian tube occlusion with degradable biopolymer implant, transcervical approach, including transvaginal ultrasound
- 0568T – Introduction of mixture of saline and air for sonosalpingography to confirm occlusion of fallopian tubes, transcervical approach, including transvaginal ultrasound and pelvic ultrasound

Medicare Update

- Conversion factor for 2020 – $36.09 – up $.05
- CMS NOT going to collapse office visit payments into one rate
- Providers to continue to use G-codes for Radiation Therapy
- CMS continuing to review Global Surgery billing for possible changes
- Increase in reimbursement for ED visit levels 1 – 4

Chronic Care Management

- +G2058 – Chronic Care Management by clinical staff – each additional 20 minutes

- Same requirements as Chronic Care Management
- No more than 2 units

Chronic Care Management – Requirements

- Complex Chronic Care Management 99487-99489 does not require revision of care plan

Care Plan should typically contain: problem list, expected outcome and prognosis, measurable treatment goals, cognitive and functional assessment, symptom management, planned interventions, medical management, environmental evaluation, caregiver assessment, interaction with outside resources, practitioners and providers, requirements for periodic review, and revision of are plan when necessary.

Expect more changes to code definitions in 2021

Transitional Care Management

- Increase in reimbursement

- 14 codes previously bundled may now be billed separately: Prolonged Services without Direct Patient Contact (99358-99359), Home and Outpatient International Normalized Ratio (INR) Monitoring Services (93792-93793), ESRD Services (90960-90970), Analysis of Data (99091), Complex Chronic Care Management Services (99487-99489), Chronic Care Management Services (99490-99491), Care Plan Oversight Services (G0181-G0182)

Principal Care Management

Care management for a patient with a single serious and high-risk condition that lasts around 3 months in a typical case.

- Condition of sufficient severity to place the patient at risk of hospitalization or has recently caused the patient to be hospitalized.
- Requires development or revision of disease-specific care plan with frequent adjustments to the medication regimen.

- G2064 - care management services furnished by the billing practitioner
- G2065 - care management services furnished by clinical staff under the billing practitioner's supervision

Medicare Final Rule

TABLE 24: Principal Care Management Services Summary

PCM Service Summary*
Verbal Consent • Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance). • Document that consent was obtained.
Initiating Visit for New Patients (separately paid)
Certified Electronic Health Record (EHR) Use • Structured Recording of Core Patient Information Using EHR (demographics, problem list, medications, allergies).
24/7 Access ("On Call" Service)
Designated Care Team Member
Disease Specific Care Management Disease Specific Care Management may include, as applicable: • Systematic needs assessment (medical and psychosocial). • Ensure receipt of preventive services. • Medication reconciliation, management and oversight of self-management.
Disease Specific Electronic Care Plan • Plan is available timely within and outside the practice (can include fax). • Copy of care plan to patient/caregiver (format not prescribed). • Establish, implement, revise or monitor the plan.
Management of Care Transitions/Referrals (e.g., discharges, ED visit follow up, referrals, as applicable). • Create/exchange continuity of care document(s) timely (format not prescribed).
Home- and Community-Based Care Coordination • Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits, as applicable.
Enhanced Communication Opportunities • Offer asynchronous non-face-to-face methods other than telephone, such as secure email.

*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of PCM.

Opioid Use Disorder – Treatment

Monthly bundle of services for the treatment of OUD that includes:

- Overall management
- Care coordination
- Individual and group psychotherapy
- Substance use counseling
- Add-on code for additional counseling

Allows clinicians to bill for OUD services in the office similar to the services being paid for under the new OTP benefit

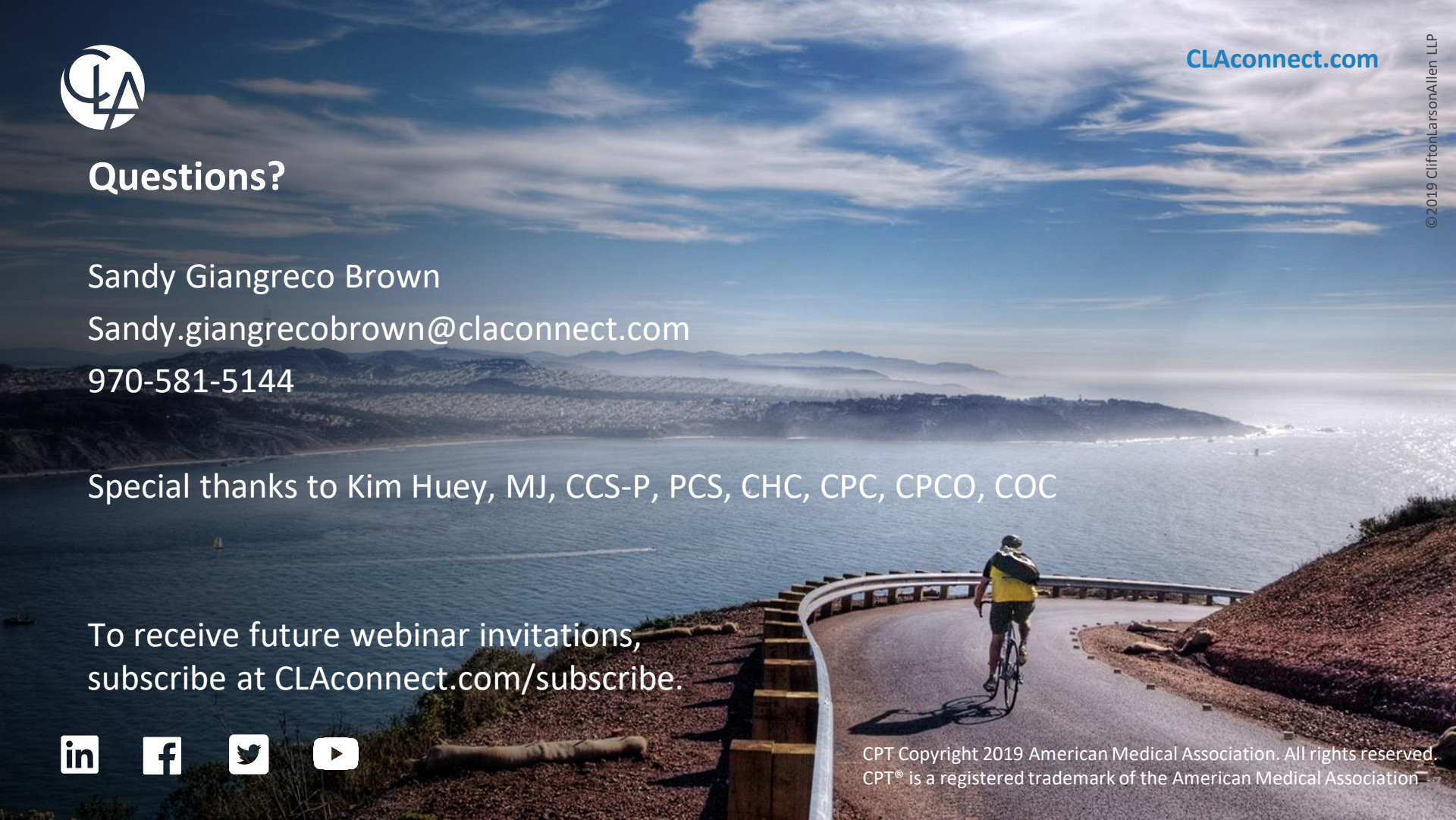
Office-Based Treatment

- G2086 – Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month
- G2087 – at least 60 minutes in a subsequent calendar month
- +G2088 – each additional 30 minutes beyond the first 120 minutes

Also codes for Medication Assisted Treatment and other services related to Opioid Treatment Program

2021 Preview

- Office visits will be coded on either total time or medical decision-making
  - Provider will still need to document a medically-appropriate history and examination
- Other sites of service will continue to use existing guidelines (for now!)
- Medicare payment for office visits will increase an average of 13%.
- New prolonged services code – 15 minutes duration – ~$22
- New add-on code for primary care or medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition – ~$15



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Questions?

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Special thanks to Kim Huey, MJ, CCS-P, PCS, CHC, CPC, CPCO, COC

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