KOHLER HEALTHCARE CONSULTING

2023 CPT Annual Update

Ohio Western Reserve AAHAM
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Charlotte Kohler
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Charlotte Kohler is the President of Kohler HealthCare Consulting, Inc. and has over 40 years of healthcare experience ranging from nursing to finance and compliance. Charlotte has experience with coding of outpatient services as well as charge capture and hospital charge master improvements. She has educated many providers and coders – utilizing both clinical and operational perspectives. She has reviewed current charging and coding methodologies to ascertain potential audit liability and to improve income potential. She is frequently called upon to assist providers through difficult coding and compliance issues. Charlotte has received the HFMA Founder's Medal of Honor as well as the Follmer Bronze, Reeves Silver and Muncie Gold awards.

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Lauren Shea

CPA, FHFMA, CPC

Lauren Shea, is a Vice President with Kohler HealthCare Consulting, Inc. As a Certified Public Accountant, Certified Professional Coder, and Fellow of the HealthCare Financial Management Association, she has more than 25 years of experience in the healthcare industry including charge master, charge capture, and charge compliance. Ms. Shea has experience both within and beyond Maryland in hospital and non-hospital settings. She often serves as a "facilitator" between clinical and financial teams.

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DISCLAIMERS

This is a high-level CPT update. We will not discuss every code and/or description change in detail.

This presentation is organized in CPT order according to 'Appendix B – Summary of Additions, Deletions and Revisions' in the 2023 CPT Professional coding book.

Explanatory Notes – It is important to review these notes for each section. Some will be discussed today.

Just because a new code is developed does not mean the service will be covered by Medicare or other payers – watch carefully for denials.

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OBJECTIVES

Participants will be able to:

- Recognize 2023 revised, added and deleted CPT* codes.
- Discuss rationales for major changes.
- Discuss other updates effective January 1, 2023.

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AGENDA

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2023 CPT Changes Overview

- There are more than 10,900 CPT codes in the 2023 code set with several hundred editorial changes.
- Total update counts vary. Some include all changes since January 1, 2022 (quarterly and ad hoc updates). Others include only January 1, 2023 updates.
- More than 220 new codes are being added and almost 93 code descriptors have been revised.
- Many of the revisions are semantic in nature vs. changes in the actual use of the codes.
- More than 70 codes will be deleted.
  - ⇨ Some will be replaced while others are outdated and have been deemed no longer necessary by the AMA.

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CPTs – from the AMA Symposium

High Level Overview – 2023 Code Set Changes

	Added	Deleted	Revised
Evaluation and Management Services	1	26	50
Anesthesia	0	0	0
Surgery	33	19	20
Radiology Procedures	1	0	5
Pathology and Laboratory Procedures	12	0	4
Medicine Services and Procedures	38	0	9
Category II Codes	0	0	0
Category III Codes	70	23	1
PLA Codes	70	7	4
Total	**225**	**75**	**93**

393 Total changes

10,969 Total codes in 2023 code set

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HCPCS – from CMS

HCPCS Range	Services	Additions	Deletions	Revisions	Total
A	Supplies	1		4	5
C	Outpatient clinic, Pharmacy, Supplies, and Surgery	63	4	3	70
E and K	Equipment	1	2	1	4
G	Behavioral Health, Chronic Pain Management and Treatment, Dental* Rehabilitation, Home Health, MIPS, Prolonged Services, Quality	10	37	92	139
J	Pharmacy	37	2	3	42
M	MIPS, Quality	66	2	2	70
Q	Pharmacy and Skin Substitutes	5			5
Total		**183**	**47**	**105**	**335**

*Yes, these are Dental G-codes, not D-codes!

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Thoughts from the Symposium

- Evaluation and Management and Digital Medicine include the most significant updates.
- The Symposium did acknowledge the challenges providers face because payers are issuing policies in direct conflict with proper coding rules – be sure to not apply rules across the board (example: recent payer policy regarding not using modifier -57 and always using modifier -25.
- The AMA and CMS are working together on key initiatives such as Behavioral Health.

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Evaluation and Management

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E/M – Summary

- Although these massive changes impact professional fee providers, some issues may/will spill over to the hospital side.
- The major change started in 2021 – when office visit codes moved from the 95/97 Guidelines (History Exam, Medical Decision Making).
- 2023 takes the new approach of Medical Decision Making (MDM) or Time to the rest of the E/M codes.
- Plus, elimination and changes to streamline and remove certain code sets.
- Clarifications will continue to come from the AMA and CMS so continue to ask questions.

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E/M – Summary

- **Numerous updates due to:**
  - Collapsing of certain codes when the underlying services are similar (e.g., inpatient and observation),
  - Revising and adding codes when the underlying services are not similar (e.g., prolonged services), and
  - Allowing services to be performed on the same day when they are distinct (e.g., emergency department visit and critical care).
- **Inpatient coding and other E/M will mirror office visit coding**
  - MDM or time will determine E/M level
    - Only appropriate history and exam
    - Find the MDM guidelines on pages 6-11 of the CPT Professional Manual, multiple updates and clarifications including separate guidebook for straight forward, low, moderate, and high – must relate to current encounter
    - No decision-making or physician presence required for lowest levels – CPT 99211 and 99281
    - Appendix C examples removed – may return in future
    - Time not permitted for Emergency Department
  - Will reduce administrative burden on physicians
    - Lessen time spent on unnecessary documentation

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Evaluation and Management

Overview of E/M changes: 1 new, 49 revisions, 25 deletions

New Code: 99418

Revised Codes: 99221-99223, 99231-99239, 99242-99245, 99252-99255, 99281-99285, 99304-99310, 99315-99316, 99341-99342, 99344-99345, 99347-99350, 99417, 99446-99451, 99483, 99495-99496

Deleted Codes: 99217-99220, 99224-99226, 99241, 99251, 99318, 99324-99238, 99334-99337, 99339-99340, 99343, 99354-99357

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E/M Comparison

Hospital Inpatient Services: Revised Descriptors

2022	2023
99221 **Initial hospital care,** per day, for the evaluation and management of a patient, which requires these 3 key components: ▪ **A detailed or comprehensive history;** ▪ **A detailed or comprehensive examination; and** ▪ **Medical decision making that is straightforward or of low complexity.** Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	▲99221 **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

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Evaluation and Management

Observation Services collapsing into **Inpatient** codes

- Initial Observation Care
  - **99218-99220** have been deleted
  - Use 99221-99223
- Subsequent Observation Care
  - **99224-99226** have been deleted
  - Use 99231-99233
- Observation Care Discharge Services
  - **99217** has been deleted
  - Use 99238 and 99239

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Evaluation and Management

Observation Services collapsing into **Inpatient** codes

- The title for this section is now "Inpatient and Observation Care."
- Mixing Inpatient and Observation seems a bit crazy, but it's the use of the Place of Service that resolves it for payers:
  - 21 – Inpatient
  - 22 – Outpatient
- Exacerbation of patient's confusion regarding Observation?
- Medicare is still holding to its time requirements before use.

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Evaluation and Management

Inpatient Codes

Updated description includes use of MDM and time. Initial means the first time the physician (or a member of the same group) sees the patient.

INITIAL			SUBSEQUENT		
Code	MDM	Time	Code	MDM	Time
99221	S/F or LOW	40	99231	S/F or LOW	25
99222	MOD	55	99232	MOD	35
99223	HIGH	75	99233	HIGH	50

If separate/unrelated service on the same day, use modifier 25 on a subsequent code.

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Evaluation and Management

Admission and Discharge on the Same day

Must have 2 or more visits on that day.

Code	MDM	Time
99234	S/F or LOW	45
99235	MOD	70
99236	HIGH	85

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Evaluation and Management

Outpatient consultation revisions to incorporate observation and leveling updates

Codes 99242, 99243, 99244, 99245

- Updates to align with the outpatient code set MDM & Time (99202-99215)
- Minor changes to language but not concepts – still required
- Deletion on Concurrent Care and Transfer of Care
- Added Qualified Health Care Professional

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Evaluation and Management

Inpatient consultation revisions to incorporate observation and leveling updates

Now named "Inpatient and Observation Consultations"

Code	MDM	Time
99252	S/F	35
99253	LOW	45
99254	MOD	60
99255	HIGH	80

- Includes: inpatient, observation, nursing facilities, partial hospital settings
- For new or established patient
- Limited to one consultation per admission
- **Deleted: 99251** (similar to 99201 rationale)

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Evaluation and Management

Discharge service revisions to incorporate observation

Revised Codes:

- **99238** – Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter
- **99239** – Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter

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Evaluation and Management

Emergency Department revisions to incorporate leveling updates

- The ED codes did not change: 99281 – 99285
- Changes in MDM:
  - 99281 – N/A
  - 99282 – Straightforward
  - 99283 – Low
  - 99284 – Moderate
  - 99285 – High
- The descriptions have changed putting into play the use of MDM --- NOT Time
- One big surprise: Level 1 (99281) now aligns with 99211 – requiring no physician intervention.
- Open question: will this impact EMTALA reporting?

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Evaluation and Management

Care Plan Oversight collapsed into management or principal care management

Care Plan Oversight Services – **Deleted: 99339-99340**

Use Management Service codes: 99491 and +99437 *or*

Principal Care Management codes: 99424-99425

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Evaluation and Management

Prolonged Services – note that CMS has their own G-codes

New:

- **+99418** – Prolonged inpatient or observation evaluation and management service[s] time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)

Revised:

- **+99417** – Prolonged ~~office or other~~ outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, ~~on the date of the primary service,~~ each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

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Evaluation and Management

Prolonged Care Services collapsing into other codes

Outpatient, home or residence service, or cognitive assessment and care plan prolonged services –

Deleted: **99354-99355**

Use CPT 99417

Inpatient or observation or nursing facility service prolonged services –

Deleted: **99356-99357**

Use CPT 99418

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Prolonged Service on Date Other Than the Face-to-Face Evaluation and Management Service Without Direct Patient Contact

- Provided on a date other than date of face-to-face E/M service.
- May be used with any E/M code whether time was used to determine level or not.
- Must relate to a service or patient which face-to-face patient care has occurred or will occur AND relate to ongoing management of care.
- CMS is proposing to label codes 99358-99359 with an invalid indicator.
  - Would make them non-payable for Medicare patients.
  - Must use G0316-G0318 and G2212 codes and rules differ.

Note: Prolonged Service CPTs cannot be used with psychotherapy codes and minute coding rules are very specific.

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Prolonged Service on Date Other Than the Face-to-Face Evaluation and Management Service Without Direct Patient Contact

99358 – Prolonged evaluation and management service before and/or after direct patient care; first hour

+99359 – Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)

Total Duration	Code(s)
< 30 minutes	Not reported separately
30-74 minutes	99358 x 1
75-104 minutes	99358 x 1 AND 99359 x 1
105+ minutes	99358 x 1 AND 99359 x 2 or more for each additional 30 minutes

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Evaluation and Management

Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision **did not change for 2023**

The key word here is *Supervision* – this is a service performed by clinical staff.

- **+99415** – Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service) (Use 99415 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215)
- **+99416** – Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service) (Use 99416 in conjunction with 99415)

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Evaluation and Management

Non-Face-to-Face Services

Revised:

Descriptors for the following codes are revised for consistency to include:

"or other qualified healthcare professional"

- **99446**
- **99447**
- **99448**
- **99449**

And 99451, shown here:

- **99451** – Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time

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Evaluation and Management

Cognitive Assessment and Care Plan clarification on timing and face-to-face

Revised:

99483 – Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements:

- Cognition-focused evaluation including a pertinent history and examination,
- Medical decision making of moderate or high complexity,
- Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity,
- Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]),
- Medication reconciliation and review for high-risk medications,
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s),
- Evaluation of safety (eg, home), including motor vehicle operation,
- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks,
- Development, updating or revision, or review of an Advance Care Plan,
- Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support.

Typically, ~~50~~ 60 minutes are spent ~~face-to-face~~ with the patient and/or family or caregiver.

Note: This is on the date of the encounter.

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Evaluation and Management

Transitional Care clean up

Revised:

99495 – Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- ~~Medical decision making of at least moderate complexity during the service period~~
- At least moderate level of medical decision making during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496 – Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- ~~Medical decision making of high complexity during the service period~~
- High level of medical decision making during the service period.
- Face-to-face visit, within 7 calendar days of discharge

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Evaluation and Management

Clarification to Use E/M codes in Delivery Room Attendance

99464 – Delivery Room Attendance

99465 – Delivery/Birth Resuscitation

→ can be used with inpatient care codes (99221 – 99223) as well as critical care (99291)

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Evaluation and Management

Recap

- Inpatient E/M leveling will mirror outpatient E/M levelling
  →MDM or time
- Deletion/collapse of observation codes
  →Inpatient E/M code definition revision to include observation services
- Deletion/collapse of code 99318 (annual nursing facility assessment)
  →Use subsequent nursing facility care codes (99307-99310)
- Deletion/collapse of domiciliary, rest home, or custodial care service codes
  →Home/residence E/M code definition revision to include these patients
- Deletion of face-to-face prolonged codes 99354-99357
- Removal of Appendix C (E/M Clinical Examples)

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Other E/M Notes

- CMS has clarified the definition of HCPCS G2211.
- Where the service occurs drives code range.
- A transition is not a new encounter.
- Avoid "always the case" internal rules, because judgment should be unique to each patient encounter – patients can and do stabilize. The same condition is not the same for individual patients and their encounters.
- Watch for additional clarifications regarding split/shared E/M services and FAQs already online; keep submitting questions. https://www.cms.gov/files/document/faqs-split-or-shared-visits-and-critical-care-services.pdf

Recently released: CPT Errata-Technical Corrections https://www.ama-assn.org/system/files/cpt-corrections-errata-2023.pdf?mibextid=Zxz2cZ
E/M Corrections Document https://www.ama-assn.org/system/files/correction-cpt-e-m-2023.pdf?mibextid=Zxz2cZ

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Polling Question #1

Were you expecting the E/M updates?
Are you feeling ready for January 1st?

1-Yes

2-No

3-Not Sure

4-N/A to my organization

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Surgery

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Surgery

Overview –

Most significant updates for abdominal hernia repairs

Section	Additions	Revisions	Deletions	Total Updates
Integumentary	3	1	1	5
Musculoskeletal	1	2	0	3
Respiratory	1	0	0	1
Cardiovascular	7	1	0	8
Digestive	17	0	18	35
Urinary	0	2	0	2
Male genital	1	0	0	1
Nervous	0	7	0	7
Eye and ocular adnexa	0	2	0	2
Auditory	3	5	0	8
Total Surgery	**33**	**20**	**19**	**72**

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Surgery – Integumentary

These updates were made because certain procedures no longer have a global period that would have included the removal of sutures and/or staples. One set requires anesthesia and other set does not.

New Codes for implantation of absorbable mesh and removal of sutures.

- **15778** – Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma
- **+15853** – Removal of sutures or staples not requiring anesthesia (List separately in addition to E/M code)
- **+15854** – Removal of sutures and staples not requiring anesthesia (List separately in addition to E/M code) – in office

Revision

- **15851** – Removal of sutures or staples ~~under~~ requiring anesthesia (other than local), ~~other surgeon~~

Deleted

- **15850** – Removal of sutures under anesthesia (other than local), same surgeon

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Surgery – Musculoskeletal

New code for total disc arthroplasty.

- **+22860** – Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)
  - Replaces **deleted** code **0163T** (Total disc arthroplasty [artificial disc], anterior approach, including discectomy to prepare interspace [other than for decompression], each additional interspace, lumbar). Typically, a -62 modifier is used with these services.

Revised for grammatical issues only

- **22857** – Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar
- **27280** – Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed

Although no code updates have been made, significant guidance has been added to the integumentary and musculoskeletal sections regarding delivery of medications to operative patients to either prevent or treat infections. In addition, guidance related to amputations has been added.

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Surgery – Respiratory

New Code:

- **30469** – Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling
  - →This helps patients with weakening of nasal cartilage to facilitate breathing.
  - →A 52-modifier is used if only one side of the nose.
  - →A wand creates a lesion that creates a scar to open the valve.
  - →Although this service does not use an endoscope, an endoscope can be used for other procedures the patient might be having that day.

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Surgery – Cardiovascular

New Codes for percutaneous pulmonary artery revascularization by stent placement (not balloon)

- **33900** – Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral
  - **33901** – normal native connections, bilateral
  - **33902** – abnormal connections, unilateral
  - **33903** – initial; abnormal connections, bilateral
- **+33904** – Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections (List separately in addition to code for primary procedure)

Normal connections exist where blood flows normally. Abnormal are variations typically related to congenital diseases. This service cannot be reported with balloon angiography services in the Medicine section. "Road mapping" angiography is included, however, if complete studies are done ahead of this service for diagnostic purposes, they are reportable.

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Surgery – Cardiovascular

New codes for reporting percutaneous arteriovenous fistula creation in the upper extremity – significant bundling including imaging

- **36836** – Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation [SINGLE ACCESS SITE = ELLIPSYS VENDOR CURRENTLY]
- **36837** – Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation [MULTIPLE ACCESS SITE = WAVELINQ = VENDOR CURRENTLY]

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Surgery – Cardiovascular

Revised:

- **35883** – Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, ~~Dacron~~ polyester, ePTFE, bovine pericardium)

Removal of trade name to generic, no change in usage of code.

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Surgery – Digestive

- Greatest number of changes in surgery subsection for 2023 to reflect the current breadth of anterior abdominal hernia repair services.
- Major revisions to hernia repair codes

  Codes have been broken down to include:
  - Location of hernia
    - → Anterior
    - → Parastomal
  - Total length (how to measure has been clarified) – the size has shown to be more reflective of underlying resources than the approach.
  - Type
    - → Initial
    - → Recurrent
    - → Reducible
    - → Incarcerated or strangulated

❖Anterior Abdominal Hernia Repair codes are no longer 90-day globals; they are 0-day globals. Mesh is typically included because it is almost always used.

❖No changes relating to colonoscopy coding this year but watch for expanded coverage by CMS.

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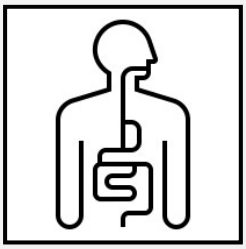
Surgery – Digestive

New Codes related to weight loss services for morbidly obese patients.

- **43290** – Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon
- **43291** – with removal of intragastric bariatric balloon(s)

Do not use foreign body removal codes.



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Surgery – Digestive

New codes for repair of anterior abdominal hernias

- 49591 – Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
  - 49592 - less than 3 cm, incarcerated or strangulated
  - 49593 - 3 cm to 10 cm, reducible
  - 49594 - 3 cm to 10 cm, incarcerated or strangulated
  - 49595 - greater than 10 cm, reducible
  - 49596 - greater than 10 cm, incarcerated or strangulated

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Surgery – Digestive

- 49613 – Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
  - 49614 - less than 3 cm, incarcerated or strangulated
  - 49615 - 3 cm to 10 cm, reducible
  - 49616 - 3 cm to 10 cm, incarcerated or strangulated
  - 49617 - greater than 10 cm, reducible
  - 49618 - greater than 10 cm, incarcerated or strangulated

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Surgery – Digestive

	Size	Severity of Hernia(s)	Anterior Abdominal Hernia(s) Repair Code
Initial	< 3 cm	Reducible	49591
		Incarcerated/Strangulated	49592
Recurrent	< 3 cm	Reducible	49613
		Incarcerated/Strangulated	49614
Initial	3 cm to 10 cm	Reducible	49593
		Incarcerated/Strangulated	49594
Recurrent	3 cm to 10 cm	Reducible	49615
		Incarcerated/Strangulated	49616
Initial	> 10 cm	Reducible	49595
		Incarcerated/Strangulated	49596
Recurrent	> 10 cm	Reducible	49617
		Incarcerated/Strangulated	49618

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Surgery – Digestive

New codes for repair of parastomal hernias

- **49621** – Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible
  - **49622** – Incarcerated or strangulated

New code for removal of total or near total non-infected mesh or other prosthesis

- **+49623** – Removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure)

  -For removal of infected mesh, use 11008.

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Surgery – Digestive

Deleted:

- **49560** – Repair initial incisional or ventral hernia; reducible
- **49561** – Repair initial incisional or ventral hernia; incarcerated or strangulated
- **49565** – Repair recurrent incisional or ventral hernia; reducible
- **49566** – Repair recurrent incisional or ventral hernia; incarcerated or strangulated
- **49568** – Implantation of mesh* or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)

*This is now included in the repair codes 49591-49618.

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Surgery – Digestive

Deleted epigastric and umbilical repair codes as these are now lumped into the anterior abdominal wall.

- **49570** – Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)
- **49572** – Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated
- **49580** – Repair umbilical hernia, younger than age 5 years; reducible
- **49582** – Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated

▶(For hernia repairs, see 49591-49618)◀

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Surgery – Digestive

- **49585** – Repair umbilical hernia, age 5 years or older; reducible
- **49587** – Repair umbilical hernia, age 5 years or older; incarcerated or strangulated
- **49590** – Repair spigelian hernia
- **49652** – Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
- **49653** – Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated

▶(For hernia repairs, see 49591-49618)◀

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Surgery – Digestive

- **49654** – Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible
- **49655** – Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated
- **49656** – Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible
- **49657** – Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated

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Surgery – Digestive

Anterior Abdominal Hernia Repair

Codes 49591-49618 describe repair of an anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian*) by any approach (ie, open, laparoscopic, robotic). Codes 49591-49618 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s), measured as the maximal craniocaudal or transverse distance between the outer margins of all defects repaired. For example, "Swiss cheese" defects (ie, multiple separate defects) would be measured from the superior most aspect of the upper defect to the inferior most aspect of the lower defect. In addition, the hernia defect size should be measured prior to opening the hernia defect(s) (ie, during repair the fascia will typically retract creating a falsely elevated measurement).

When both reducible and incarcerated or strangulated are repaired at the same operative session, code up to 49594.

Not included in these codes, but separately reportable –

Append modifier 59 if repairing an *inguinal, femoral, lumbar, omphalocele, and/or parastomal hernia* repair at the same operative session as the anterior abdominal hernia repair.

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Surgery – Urinary

Revised to reflect current guidelines – these are only the antegrade codes which means the approach is the same direction as urine flows in the body. The 2cm measurement is because 2 cm or less is usually in one location whereas > 2 cm indicates multiple locations and other complexities including the need for multiple access points:

- **50080** – Percutaneous ~~nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy,~~ nephrolithotomy or pyelolithotomy, lithotripsy, ~~stenting, or basket~~ stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones)
  - **50081** – complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)

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Surgery – Male Genital

New code for laparoscopic simple prostatectomy – this used to be reportable via an unlisted code only because the procedure was done open.

- **55867** – Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed

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Surgery – Nervous System

Revised to bundle imaging guidance; some codes in this range still allow separate reporting of imaging guidance and there is a table in CPT on pg. 479 to assist.

- **64415** – Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed
  - **64416** – brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
  - **64417** – axillary nerve, including imaging guidance, when performed
  - **64445** – sciatic nerve, including imaging guidance, when performed
  - **64446** – sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
  - **64447** – femoral nerve, including imaging guidance, when performed
  - **64448** – femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed

Although no changes to the actual codes, there is additional guidance relating to CPTs 22630-22634, 63034-63057, and 64490-64495. The AMA is continuing to clarify proper spinal reporting.

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Surgery –
Surgical Procedures on the Eye and Ocular Adnexa

Revised with current Food and Drug Administration (FDA) terminology – does not affect usage of code.

- **66174** – Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent
  - **66175** – with retention of device or stent

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Surgery – Auditory

New additions and revisions as there has been more experience with Bone Anchored Hearing Aids (BAHAs). These codes were added in 2022 and there are variations with how the services are performed and the resources differ based on how much bone is being removed and the location of the implant:

- **69716** – Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex
- **69717** – ~~Revision or~~ Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor
- **69719** – Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex
- **69726** – Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor
  - **69727** – with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex

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Surgery – Auditory

- **69728** – Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex
  - **69729** – with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex
- **69730** – Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex

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Radiology

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Radiology

Watch for continued bundling of imaging such as fluoroscopy and ultrasound into surgical services (for example, CPTs 36836-36837) where the surgical code is captured by HIM, and the imaging department may not be able to charge. There are many new technology codes relating to imaging.

Overview: 1 new code, 5 revisions

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Radiology

Revised:

- **76882** – Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation

New:

- **76883** – Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity

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Radiology

Revised in definition but not usage of code to clarify when to code multiple on same day (multiple radiopharmaceuticals):

- **78803** – Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging
  - **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) or acquisition, single day imaging
  - **78831** – tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition 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, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days

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Laboratory

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Laboratory

Overview:

82 new codes (not all included)

7 revisions

7 deletions

Most changes in PLAs and Molecular Pathology and there are New Technology digitization codes.

Section	Additions	Revisions	Deletions	Total Updates
Molecular Pathology	5	3		8
Chemistry	1			1
Microbiology	6			5
PLA	70	4	7	81
Total Surgery	82	7	7	95

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Laboratory

New codes for molecular pathology:

- **81418** – Drug metabolism (eg, pharmacogenomics) genomic sequence analysis panel, must include testing of at least 6 genes, including CYP2C19, CYP2D6, and CYP2D6 duplication/deletion analysis

If there are fewer than 6 genes, use other CPTs.

- **81441** – Inherited bone marrow failure syndromes (IBMFS) (eg, Fanconi anemia, dyskeratosis congenita, Diamond-Blackfan anemia, Shwachman-Diamond syndrome, GATA2 deficiency syndrome, congenital amegakaryocytic thrombocytopenia) sequence analysis panel, must include sequencing of at least 30 genes, including BRCA2, BRIP1, DKC1, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, GATA1, GATA2, MPL, NHP2, NOP10, PALB2, RAD51C, RPL11, RPL35A, RPL5, RPS10, RPS19, RPS24, RPS26, RPS7, SBDS, TERT, and TINF2

This helps with reporting, so laboratories do not need to use a combination of codes.

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Laboratory

These codes are to be used regardless of methodology. Note that these are for RNA analysis only – there are existing codes for RNA and DNA together.

- **81449** – Targeted genomic sequence analysis panel, solid organ neoplasm, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed; RNA analysis
- **81451** –Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NOTCH1, NPM1, NRAS), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis
- **81456** – Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes (eg, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MET, MLL, NOTCH1, NPM1, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis

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Laboratory

Revised in line with the previous additions for DNA and RNA together:

- **81445** – Targeted genomic sequence analysis panel, solid organ neoplasm, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed; DNA analysis or combined DNA and RNA analysis
- **81450** – Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NOTCH1, NPM1, NRAS), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis
- **81455** – Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes (eg, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MET, MLL, NOTCH1, NPM1, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis

Note: 0016M Administrative Multianalyte Assays with Algorithmic Analyses (MAAAs) revised from 209 to 219 genes.

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Laboratory – Chemistry

New code added for specificity instead of 82657 not otherwise specified coding relating to medication interventions

- **84433** – Thiopurine S-methyltransferase (TPMT)

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Laboratory – Microbiology

New codes:

- **87467** – Hepatitis B surface antigen (HBsAg), quantitative

This is different from existing codes for qualitative and used for monitoring therapies being used for patients with chronic hepatitis.

- **87468** – Infectious agent detection by nucleic acid (DNA or RNA); Anaplasma phagocytophilum, amplified probe technique
  - **87469** – Babesia microti, amplified probe technique
  - **87478** – Borrelia miyamotoi, amplified probe technique
  - **87484** – Ehrlichia chaffeensis, amplified probe technique

These updates improve the specificity of reporting; these services are already performed and reported based on the methodology used.

- **87913** – Infectious agent genotype analysis by nucleic acid [DNA or RNA]; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19]), mutation identification in targeted region(s)
  [*added before 1/1/2023*]

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Proprietary Laboratory Analyses (PLA)

Updates are made quarterly; see website at bottom to review all.

New Codes (constantly adding new ones):

- 0355U – Apolipoprotein L1 (APOL1) Renal Risk Variant Genotyping, Quest Diagnostics®, Quest Diagnostics®
- 0356U – NavDx®, Naveris, Inc, Naveris, Inc
- 0357U – DAWN™ IO Melanoma, InterVenn Biosciences, InterVenn Biosciences
- 0358U – Lumipulse® G β-Amyloid Ratio (1-42/1-40) Test, Fujirebio Diagnostics, Inc, Fujirebio Diagnostics, Inc
- 0359U – IsoPSA®, Cleveland Diagnostics, Inc, Cleveland Diagnostics, Inc
- 0360U – Nodify CDT®, Biodesix, Inc, Biodesix, Inc
- 0361U – Neurofilament Light Chain (NfL), Mayo Clinic, Mayo Clinic
- 0362U – Thyroid GuidePx®, Protean BioDiagnostics, Protean BioDiagnostics
- 0363U – Cxbladder™ Triage, Pacific Edge Diagnostics, USA Ltd, Pacific Edge Diagnostics, USA Ltd

Deleted Codes (either no longer needed, no longer offering, or moved to Cat 1 code):

- 0151U – Infectious disease (bacterial or viral respiratory tract infection), pathogen specific nucleic acid (DNA or RNA), 33 targets, real-time semi-quantitative PCR, bronchoalveolar lavage, sputum, or endotracheal aspirate, detection of 33 organismal and antibiotic resistance genes with limited semi-quantitative results
- 0208U – Oncology (medullary thyroid carcinoma), mRNA, gene expression analysis of 108 genes, utilizing fine needle aspirate, algorithm reported as positive or negative for medullary thyroid carcinoma

Be sure to watch for PLA updates: https://www.ama-assn.org/practice-management/cpt/cpt-pla-codes

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Polling Question #2

Are you currently billing and being reimbursed for any PLA laboratory services?

1-Yes

2-No

3-Not Sure

4-N/A to my organization

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Medicine

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Medicine

Overview:

38 New Codes

9 Revised Codes

Majority for vaccine administrations. There are also many new technology codes.

Section	Additions	Revisions	Total Updates
Vaccine Administration	20	1	21
Vaccines	9	1	10
Eye and Ear	2	3	5
Cardiovascular	4	1	5
Behavior Management	2		2
Monitoring	1	3	4
Total Medicine	**38**	**9**	**47**

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KOHLER HEALTHCARE CONSULTING

COVID Vaccines and Administrations

Continuously being added for COVID (49 since 2020, 21 since 2021) – currently 8 products, adding new options for bivalent, pediatric, additional doses, boosters, etc.

Providers must take time to ensure they are being appropriately applied – a third dose (for immunocompromised patients) is different from a booster dose (not immunocompromised patients), etc.

https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-coding-and-guidance

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KOHLER HEALTHCARE CONSULTING

Other Vaccine Code Updates

- **90584** – Dengue vaccine, quadrivalent, live, 2 dose schedule, for subcutaneous use

Watch for FDA approval; there is already a code for 3 dose schedule.

- **90678** – Respiratory synchtial virus vaccine, preF, subunit, bivalent, for intramuscular use

Watch for FDA approval; for adults age 60+ and pregnant women during second or third trimester.

- **90739** – Hepatitis B vaccine (HepB), CpG adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use

This was updated due to schedule changes and additional protection.

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Eye

Orthoptic Training – Eye exercises to help patients with issues focusing – clarification regarding two circumstances of service performance

- **92065** – Orthoptic training; performed by a physician or other qualified health care professional [MD OR OTHER PROFESSIONAL]
- **92066** – Orthoptic training; under supervision of a physician or other qualified health care professional [TECHNICIAN]

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Eye

Revised:

- **92229** – Imaging of retina for detection or monitoring of disease; point-of-care autonomous analysis and report, unilateral or bilateral

Revised from autonomous to automated for clarity because the machine automatically interprets data and provides diagnosis and/or treatment plan.

- **92284** – Diagnostic dark adaptation examination with interpretation and report

This examination is diagnostic, not a screening. Looking issue for issues with the retina including but not limited to macular degeneration.

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Eye

New code for quantitative pupillometry (measuring the size and reactivity of the pupil).

- **95919** – Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral

This used to be reportable via an unlisted code and can be used to predict and diagnose conditions proactively; for example, eye complications from diabetes.

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Audiology

No code updates but watch for new modifier **(AB)** for situations of where an audiologist performs non-acute hearing assessment services without a physician order.

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Cardiovascular

New codes and **revisions** for injection procedures during cardiac catheterization.

- **+93568** – Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for nonselective pulmonary arterial angiography (List separately in addition to code for primary procedure)
- **+93569** – Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, unilateral (List separately in addition to code for primary procedure)
  - **+93573** – for selective pulmonary arterial angiography, bilateral (List separately in addition to code for primary procedure)
  - **+93574** – for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization (List separately in addition to code for primary procedure)
  - **+93575** – for selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches, during cardiac catheterization for congenital heart defects, each distinct vessel (List separately in addition to code for primary procedure)

These codes differentiate between arterial and venous procedures during catheterization cases and the imaging codes in the 7xxxx series already differentiate. These codes already include the introduction and positioning of catheters, injections, and imaging.

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Mental/Behavioral Health: Caregiver Behavior Management

New codes for multi-family group behavior management

- **96202** – Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes
  - **+96203** – each additional 15 minutes (List separately in addition to code for primary service)

Example: Parents of Attention Deficit Hyperactivity Disorder (ADHD) patients or parents dealing with pediatric obesity. Parents can be in these groups while children are in a psychotherapy group. Must be multiple patients/families involved. Detailed guidelines in CPT.

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Mental/Behavioral Health: Monitoring

Revised and **new** to expand usage for cognitive behavioral monitoring:

- **98978** – Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days

Former Category III codes **0702T-0703T** were deleted.

- **98975** – Remote therapeutic monitoring (eg, ~~respiratory system status, musculoskeletal system status,~~ therapy adherence, therapy response); initial set-up and patient education on use of equipment
  - **98976** – device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
  - **98977** – device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days

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New Technology

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Category III Codes

Overview:

- **68 New Codes**
- **3 Revisions**
- **23 Deleted Codes** (most were not replaced with a category I code)

Codes for reporting emerging technology, services, and procedures. Added throughout the year.

All codes not included.

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New Technology – Digital Medicine

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Digital Medicine –
Innovation and Technology is growing.

- Understanding new terminology
  - Assistive – can detect (has existed for a long time)
  - Augmentative – can analyze and/or quantify
  - Autonomous – levels I through III (new/emerging)
- Appendices P (synchronous telemedicine), R (digital medicine taxonomy), S (artificial intelligence taxonomy), and T (audio-only telemedicine) to ensure providers are handling consistently even though payer decisions will differ
- Modifiers:
  - 93 = Realtime Audio-Only
  - 95 = Realtime Audio-Visual
- Star symbol ★ = Telemedicine
- CMS continues to gather data during the PHE to see which situations and services should continue after the PHE. They promise a 60-day notice before the end of PHE with 151 days after for phase-outs.

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Digital Medicine – Cardiology

- **0716T** – Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score

  → This helps to score patients suffering from shortness of breath, fatigue, and chest pain.

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Digital Medicine – Genetics

- **0731T** – Augmentative AI based facial phenotype analysis with report
  - → Based on algorithms already developed for various DNA issues found in facial expressions, this analysis uses facial similarities to assist with diagnosis of genetic abnormalities in infants and children.

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Digital Medicine – Rehabilitation

Revised:

- **0733T** – Remote <u>real-time, motion capture-based neurorehabilitative</u> therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days
  - **0734T** – treatment management services by a physician or other qualified health care professional, per calendar

Used for post-stroke rehabilitation. This is a camera system with software that provides immediate feedback to patients. Real-Time Motion Capture Toolbox (RTMocap): an open-source code for recording 3-D motion kinematics to study action-effect anticipations during motor and social interactions. https://pubmed.ncbi.nlm.nih.gov/25805426/

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Digital Medicine – Diabetes Management

- **0740T** – Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education
  - **0741T** – provision of software, data collection, transmission, and storage, each 30 days

Calculates recommended insulin dose for Type 2 Diabetic patients and injects insulin when appropriate.

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Digital Medicine – Laboratory: Digitization of Slides

Digitization has existed; the technology is now catching up for pathology where pathologists can review specimens remotely. Digitization is coded in addition to the original pathology code(s). This area will continue to grow.

- **+0751T** – Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
  - **+0752T** - for level III
  - **+0753T** - for level IV
  - **+0754T** - for level V
  - **+0755T** - for level VI

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Digital Medicine – Laboratory: Digitization of Slides

- **+0756T** – Digitization of glass microscope slides for special stain, including interpretation and report, group I, for microorganisms (eg, acid fast, methenamine silver) (List separately in addition to code for primary procedure)
  - **+0757T** – group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry
  - **+0758T** – histochemical stain on frozen tissue block
  - **+0759T** – group III, for enzyme constituents
  - **+0760T** – immunohistochemistry or immunocytochemistry, per specimen, initial single antibody stain procedure

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Digital Medicine – Laboratory: Digitization of Slides

- **+0761T** – Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each additional single antibody stain procedure (List separately in addition to code for primary procedure)
  - **+0762T** – each multiplex antibody stain procedure
- **+0763T** – Digitization of glass microscope slides for morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure, manual (List separately in addition to code for primary procedure)

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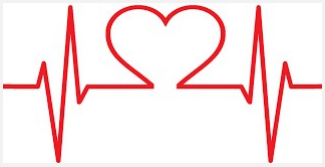
Digital Medicine – Cardiology

- **+0764T** – Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure)
  - **0765T** – related to previously performed electrocardiogram

This is a software and EKG-based algorithmic risk analysis.



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Digital Medicine – Virtual Reality (VR) – Therapy

- **+0770T** – Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)

→This is an add-on for the cost of purchasing this technology and can only be used once per therapy session – helps with social communication, regulating emotions, and daily functioning skills for patients such as autistic patients. This is technical only, not professional.

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Digital Medicine – VR instead of Sedation/Anesthesia

- **0771T** – Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older
  - **+0772T** – each additional 15 minutes intraservice time
- **0773T** – Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older
  - **+0774T** – each additional 15 minutes intraservice time (List separately in addition to code for primary service)

To not use sedation/anesthesia, this is used. Not for younger than 5 years old. The first set are where the same provider is performing the service and the VR with a trained observer. The second set are where the provider is only performing the VR. Must be 10 of 15 minutes to charge.

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Digital Medicine – Epidural Guidance

- **+0777T** – Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)

→ Provides guidance during epidural placements by using pressure-sensing method (as described above) for surgical CPTs 62320 through 62327.

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New Technology – Other

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Bronchoscopy

- **0781T** – Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi
  - **0782T** – unilateral mainstem bronchus

This service is charged once regardless of the number of treatments. This helps patients with Chronic Obstructive Pulmonary Disease (COPD) with their breathing, because if their nerves do not overreact, their bronchial tubes will not constrict as much.

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Cardiology

- **+0715T** – Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)
  - →The primary procedure(s) are the bypass grafting codes. Lithotripsy is not just for kidney stones! An intravascular lithotripsy category I code is pending.
- **+0742T** – Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)
  - →This is an add-on for stress tests similar to existing Nuclear Medicine 78451, 78452, and PET 78434 CPTs.
- **0744T** – Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed
  - →This valve helps with venous insufficiency.

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Cardiology continued

- **0745T** – Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance
  - **0746T** – conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan
  - **0747T** – delivery of radiation therapy, arrhythmia

There are distinct steps of mapping, radiation treatment planning, and treatment delivery. This can treat tachycardia.

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Eye

- **0730T** – Trabeculotomy by laser, including optical coherence tomography (OCT) guidance

The trabecular meshwork is the filtration system, and this procedure relates to glaucoma treatment. This is a laser, no incision, unlike existing OCT codes.

Revised:

- **0402T** – Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed, and intraoperative pachymetry, when performed

Sometimes the epithelium (the outermost layer of the cornea) can stay and does not require removal which is much less painful for the patient during recovery because otherwise, it feels like a corneal abrasion (very painful). This procedure can help diabetic patients with certain types of vision loss.

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Gastroenterology

- **0720T** – Percutaneous electrical nerve field stimulation, cranial nerves, without implantation

This treatment helps with functional abdominal pain and so far, at least one payer covers it! At this time, it is being used for pediatric patients.

- **0736T** – Colonic lavage, 35 or more liters of water, gravity-fed, with induced defacation, including insertion of rectal catheter

This is a much easier way to clear the colon using gravity-fed water for patients that cannot tolerate colonoscopy prep or are suffering from constipation.

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Gastroenterology

- **0779T** – Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report

  This is a non-invasive way to collect data to help diagnose the reasons for pain, bloating, and distention and guide associated treatments.

- **0780T** – Instillation of fecal microbiota suspension via rectal enema into lower gastrointestinal tract

  This differs from existing Fecal Microbiota Transplant (FMT) service codes because it is through an enema (no scope involved). The product is commercially prepared and processed and then thawed, enema administered, and product instilled.

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Mental/Behavioral Health

- **0783T** – Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment

  → This aids in relief of opioid withdrawal symptoms.

Note: Coaching new technology codes 0591T through 0593T now apply for any health coach. Specific certification requirements have been removed.

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Neurosurgery

- **0719T** – Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment

  This procedure helps with fusing discs to spare motion using tension bands for the lumbar spine only. This has been used for years in Europe and we are now beginning to see clinical trials in the United States.

- **+0735T** – Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (List separately in addition to code for primary procedure)

  This new product is a collagen wafer or tile that is placed in the skull for brain cancer patients and although much more complex, works similar to brachytherapy in the prostate.

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Orthopaedics

- **0717T** – Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing, and concentration of ADRCs
  - **0718T** – injection into supraspinatus tendon including ultrasound guidance, unilateral

    This cell therapy includes codes to obtain and inject for patients with tendon issues.

- **0737T** – Xenograft implantation into the articular surface

  This can be reported per graft into different joints during the same session.

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Orthopaedics continued

- **0775T** – Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s])

  This is a unique method of stabilizing the sacroiliac joint – the implant(s) uses tensioning to distract the joint. Removal of the outer layer of the bone is included.

- **0778T** – Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function

  This is in-person with the patient, not remote, to attempt to remove variability of provider measurements. The data is transmitted to the cloud.

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Otolaryngology: Vestibular Devices

- **0725T** – Vestibular device implantation, unilateral
- **0726T** – Removal of implanted vestibular device, unilateral
- **0727T** – Removal and replacement of implanted vestibular device, unilateral
- **0728T** – Diagnostic analysis of vestibular implant, unilateral; with initial programming
  - **0729T** – with subsequent programming

This device is a motion sensor and used to help patients having vertigo and balance issues. The ear is temporarily lifted, and a pocket is made in the membrane of the skull for the device. Electrodes are also used. Do not confuse with a cochlear implant used for hearing.

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Pain Management

- **0766T** – Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, initial treatment, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve
  - **+0767T** – each additional nerve (List separately in addition to code for primary procedure)
- **0768T** – Subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve
  - **+0769T** – each additional nerve (List separately in addition to code for primary procedure)

This is treatment for chronic nerve pain and not to be used in conjunction with EMG or nerve conduction. This is not "scrambler therapy." There may be services done before these to confirm diagnosis and need for service – those are separately reportable.

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Pain Management

- **0776T** – Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment

  → This is used for suspicion of concussion and reportable once per day. Typically, in an emergency room or urgent care setting.

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Prostate Services

- **0714T** – Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance
- **0738T** – Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination
- **0739T** – Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation

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Radiology: Quantifications/Imaging Post-Processing

- **0721T** – Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging
  - **+0722T** – obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)
- **0723T** – Quantitative magnetic resonance cholangiopancreatography (QMRCP), including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session
  - **+0724T** – *not during the same session* (List separately in addition to code for primary procedure)

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Radiology: Bone Strength

- **0743T** – Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report
- **0749T** – Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report
  - **0750T** – with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD

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Surgery

- **0748T** – Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)
  - → Cannot code product separately. This service can help patients with Crohn's Disease.

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Deleted New Technology Codes

- **0312T-0317T** – use unlisted CPT 64999 – Vagus nerve blocking therapy (morbid obesity)
- **0475T-0478T** – use unlisted CPT 93799 – Recording of fetal magnetic cardiac signal
- **0163T** – use +**22860** – anterior implant of a total disc arthroplasty at a second level only; report unlisted code 22899 for third and all other levels
- **0470T-0471T** – use unlisted CPT 96999 – Optical coherence tomography (OCT) for microstructural and morphological imaging of skin
- **0487T** – use unlisted CPT 58999 – Biomechanical mapping, transvaginal
- **0491T-0492T** – use unlisted CPT 17999 – Ablative laser treatment, non-contact, full field and fractional ablation, open wound
- **0493T** – use unlisted CPT 93998 – Contact near-infrared spectroscopy studies of lower extremity wounds

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Deleted New Technology Codes

- **0497T-0498T** – use unlisted CPT 93799 – External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recorder without 24-hour attended monitoring
- **0499T** – use unlisted CPT 53899 – Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis
- **0514T** – Deleted without replacement, low utilization – intraoperative visual axis identification using patient fixation

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Other Updates & Wrap-Up

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Pharmacy Modifiers

- January 1, 2023 required usage of JW modifier for waste reporting for drugs separately reimbursed (not packaged) by Medicare (i.e., administered dose less than single dose vial size)
  - Automation vs. manual applications
- July 1, 2023 required usage of JZ modifier by hospital outpatient (HOPDs) and ambulatory surgery centers (ASCs) when there is no waste for drugs separately reimbursed (i.e., administered dose = single dose vial size)
- CMS edits to be implemented 10/1/2023 if claim does not have JW or JZ
- Future usage of this data by CMS
  - Are standard vial sizes too large, can/should they be reduced to produce savings?

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Polling Question #3

Are you concerned about the pharmacy modifiers regarding waste?

1-Yes

2-No

3-Not Sure

4-N/A to my organization

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Jan 1 is Not Only About CPT Updates

- Continue to explore HCPCS Level II codes including the dental G-codes for usage with patients where dental is integral to their medical care (e.g., organ transplants and head/neck cancers), chronic pain management, and monthly behavioral health integration codes
- No Surprises Act (NSA) Good Faith Estimates (GFEs) must include co-provider items and services.
- There are significant Medicare payment and coverage updates
  - 340B drug payments return to Average Sales Price (ASP) + 6%
  - Inpatient Only (IPO) list
  - Behavioral Health – audio-only, lifting supervision barriers, non-PHP for PHP patients, monthly Behavioral Health Integration
  - N95 mask payments
  - Rural:
    - Rural Emergency Hospital (REH) – new provider type – bonuses
    - Rural sole community hospital outpatient clinics – not MPFS
  - Software as a Service – SaaS – looking for input for future
- Future:
  - July 1, 2023 – Facet prior authorizations for Medicare
  - Streamlining of wound care-related skin substitute reporting

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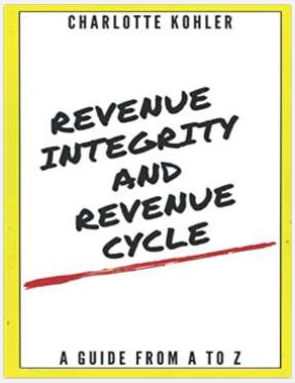
KHC Resource Guide Available

- Need help untangling the issues found in Revenue Cycle and Revenue Integrity?
- KHC has developed a resource guide for novice to seasoned professionals that provides a broad range of insights that you can use in your day-to-day encounters.



Link to Amazon

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THANK YOU

These slides were prepared by
Kohler HealthCare Consulting, Inc.
for discussion purposes.

All updates to charging and billing for 2023 should be made with original coding source documentation from the AMA and CMS.

Email Lauren Shea (lshea@kohlerhc.com) for your AAPC CEU certificate. It will be sent on or before January 15th, 2023.

Interested in our newsletter? Sign up here:
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