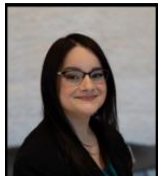
Stony Brook Medicine

1



2023 CPT/OPPS Updates

Melissa Minski, RHIA, CCS, CCDS, AHIMA Approved ICD-10-CM/PCS Trainer

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- CPT Updates
  - Surgical Updates
  - Medicine Updates
  - Category III Updates
  - Radiology
  - Evaluation & Management
  - Anesthesia
  - Pathology & Lab Updates
- OPPS Updates
  - Rate Setting Data
  - Inpatient Only Procedures
  - ASC Covered Procedures
  - ASC Non-Opioid Pain Management Program
  - 340B Drug Program
  - Behavioral Health Services
  - N95 Masks
  - Transitional Pass-Through Payments
  - Payments for Software as a Service (SaaS)
  - Dental Services

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CPT Updates

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Stony Brook Medicine

SUMMARY OF CHANGES

Chapter	New Codes	Revised Codes	Deleted Codes
Evaluation & Management	1	50	26
Anesthesia	0	0	0
Surgery	33	20	19
Radiology	1	5	0
Pathology/Lab	12	3	0
Medicine	38	9	0
Category II	0	0	0
Category III	68	3	23
PLA & MAAA	70	5	7

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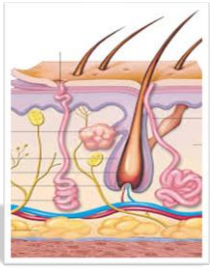
Surgery Section Update

6

Stony Brook Medicine CPT 10004-19499

Integumentary System



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7

Stony Brook Medicine NEW CPT 15778

- 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.

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Stony Brook Medicine NEW CPT 15778

- (For repair of anorectal fistula with plug [eg, porcine small intestine sub-mucosa {SIS}], use 46707) ◀
- (For implantation of mesh or other prothesis for anterior abdominal hernia repair or parastomal hernia repair, see 49591-59622)◀
- (For insertion of mesh or other prosthesis for repair of pelvic floor defect, use 57267)◀
- (For implantation of non-biologic or synthetic implant for fascial reinforcement of the abdominal wall, use 0437T)◀

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Stony Brook Medicine NEW NOTES +15847

❖**+**15847: Excision of excessive skin

➢(For inguinal hernia repair, see 49491-49525)◀

➢(For anterior abdominal hernia(s) repair, see 49591-49618)◀

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Stony Brook Medicine REVISED CODE 15851

▲15851: Removal of sutures **or** staples ~~under~~ requiring anesthesia (ie, general anesthesia, moderate sedation).

➢(15850 has been deleted. To report, use 15851)◀

➢(Do note report 15851 for suture and/or staple removal to re-open a wound prior to performing another procedure through the same incision)◀

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Stony Brook Medicine NEW CPT CODES 15853 & 15854

- **+**15853: Removal of sutures **or** staples not requiring anesthesia (list separately in addition to E/M code)

➢(Do not report 15853 in conjunction with 15854)◀

- **+** 15854: Removal of sutures **and** staples not requiring anesthesia (list separately in addition to E/M code)

➢(Do not report 15854 in conjunction with 15853)◀

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Stony Brook Medicine

NEW CPT CODES 15853 & 15854

- Use 15853 or 15854 in conjunction with:
  - ✓ 99202
  - ✓ 99203
  - ✓ 99204
  - ✓ 99205
  - ✓ 99211
  - ✓ 99212
  - ✓ 99213
  - ✓ 99214
  - ✓ 99215
  - ✓ 99281
  - ✓ 99282
  - ✓ 99283
  - ✓ 99284
  - ✓ 99285
  - ✓ 99341
  - ✓ 99342
  - ✓ 99344
  - ✓ 99345
  - ✓ 99347
  - ✓ 99348
  - ✓ 99349
  - ✓ 99350

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Stony Brook Medicine

Musculoskeletal System

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14

Stony Brook Medicine

NEW NOTES +20700 - + 20705

- Add-on codes for the preparation, insertion, and removal of drug-delivery systems.
- The location of the primary service determines which of the insertion/removal codes may be selected (i.e. deep, subfascial, intramedullary, intra-articular). ◀
- If only a removal of a deep drug delivery system is performed (with no primary procedure) assign code 20680. ◀
- These codes should not be used with other codes that include the placement of a "spacer" (i.e. 27091, 27488) ◀

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Stony Brook Medicine

NEW NOTES +20700 - + 20705

- Manual Preparation Defined:
  - …Involves the mixing and preparation of antibiotics or other therapeutic agent(s) with a carrier substance by the physician or other qualified health care professional during the surgical procedure and then shaping the mixture into a drug-delivery device(s) (e.g. beads, nails, spacers) for placement in the deep (eg, subfascial), intramedullary, or intra-articular space(s) ◀

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Stony Brook Medicine

NEW NOTES 20802-20838

- These codes are for reimplantation procedures.
  - (For repair of incomplete amputation of the arm, forearm, hand, digit, thumb, thigh, leg, foot, or toe report the specific code(s) for the repair of bone(s), ligament(s), tendon(s), nerve(s), and/or blood vessel(s) and append modifier 51 or 59 as appropriate)
  - (For replantation of complete amputation of the lower extremity, except foot, report the specific code(s) for repair of bone(s), ligament(s), tendon(s), nerve(s), and/or blood vessel(s) and append modifier 51 or 59 as appropriate)

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Stony Brook Medicine

NEW & REVISED CODES FOR TOTAL DISC ARTHROPLASTY

- ▲22857: Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar.
  - **+**22860: second interspace, lumbar (list separately in addition to code for primary procedure).
    - (Use 22860 in conjunction with 22857)◀
    - (For total disc arthroplasty, anterior approach, lumbar, more than two interspaces use 22899)◀
  - Replaced category III code 0163T which was deleted for this year.

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18

- Code 27279 describes percutaneous arthrodesis of the sacroiliac joint using a minimally invasive technique to place an internal fixation device(s) that passes through the ilium, across the sacroiliac joint and into the sacrum, thus transfixing the sacroiliac joint.
- Report code 0775T for the percutaneous placement of an intra-articular stabilization device into the sacroiliac joint using a minimally invasive technique that does not transfix the sacroiliac joint.
- For percutaneous arthrodesis of the sacroiliac joint utilizing both a transfixation device and intra-articular implant(s), use code 27299.
- This same note appears before code 0775T on page 928 of the CPT book.

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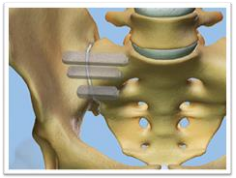

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https://dhreegenerativemedicine.com/wp-content/uploads/2021/11/LinQ2.jpg

20

https://www.youtube.com/watch?v=_jYA_pi6Ebo

21

https://www.youtube.com/watch?v=cDz-phBnGlg

22

27279: Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device.

- (Do not report 27279 in conjunction with 0775T) ◀
- (For percutaneous arthrodesis of the sacroiliac joint using both a transfixation device and an intra-articular implant (s), use 27299) ◀
- (For percutaneous arthrodesis of the sacroiliac joint by intra-articular implant(s), use 0775T) ◀

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▲27280 Arthrodesis, ~~open,~~ sacroiliac joint, open, ~~including~~ includes obtaining bone graft, including instrumentation, when performed.

- (Do not report 27280 in conjunction with 0775T)◀
- (For percutaneous/minimally invasive arthrodesis of the sacroiliac joint without fracture and/or dislocation, utilizing a transfixation device, use 27279)◀

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Stony Brook Medicine

NEW NOTES & REVISED CODE FOR SACROILIAC FUSION

- 0775T: Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (e.g. bone allograft(s), synthetic device(s))
  - ➢ (Do not report 0775T in conjunction with 27279, 27280)
  - ➢ (For percutaneous arthrodesis, sacroiliac joint, with transfixation device, use 27279)
  - ➢ (For removal or replacement of sacroiliac intra-articular implant(s), use 27299)
  - ➢ (For bilateral procedure, report 0775T with modifier 50)
  - ❖ Status J1

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Respiratory System

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Stony Brook Medicine

NEW CPT CODE 30469

- 30469: Repair of nasal valve collapse with low energy, temperature controlled (i.e. radiofrequency) subcutaneous/submucosal remodeling.
  - ❖ Required the addition of notes under code 30465:
    - ➢ (Do not report 30465 in conjunction with 30468, 30469, when performed on the ipsilateral side)
    - ➢ (For repair of nasal valve collapse with low energy, temperature controlled (i.e. radiofrequency) subcutaneous/submucosal remodeling, use 30469)

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Stony Brook Medicine NEW CPT CODE 30469

- Notes associated with 30469:
  - (Do not report 30469 in conjunction with 30465, 30468 when performed on the ipsilateral side) ◀
  - (For repair of nasal vestibular stenosis (eg spreader grafting, lateral wall reconstruction), use 30465) ◀
  - (For repair of nasal vestibular lateral wall collapse with subcutaneous/submucosal lateral wall implant(s), use 30468) ◀
  - (For Repair of nasal vestibular stenosis or collapse without cartilage graft, lateral wall reconstruction, or subcutaneous/submucosal implant (eg lateral wall suspension or stenting without graft or subcutaneous/submucosal implant), see 30999) ◀
  - (30469 is used to report a bilateral procedure. For unilateral procedure, use modifier 52) ◀

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Stony Brook Medicine NEW CPT CODE 30469

- New code 30469 also required new instructional notes under 30468:
  - (Do not report 30468 in conjunction with 30465, 30469, when performed in the ipsilateral side) ◀
  - For repair of nasal vestibular stenosis or collapse without cartilage graft, lateral wall reconstruction, or subcutaneous/submucosal implant (eg lateral wall suspension, or stenting without graft or subcutaneous/submucosal implant), use 30999) ◀

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Stony Brook Medicine

Cardiovascular System

https://images.immediate.co.uk/production/volatile/sites/34/2020/11/what-is-the-cardiovascular-system-and-how-does-exercise-affect-it-844197a.jpg?quality=90&resize=620%2C413

30

Stony Brook Medicine NEW NOTES FOR CODE 33477

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

- Includes all cardiac catheterization(s), intraprocedural contrast injection(s), fluoroscopic radiological supervision and interpretation, and imaging guidance performed to complete the pulmonary valve procedure. Do not report 33477 in conjunction with…..for angiography intrinsic to the procedure. ◀

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Stony Brook Medicine NEW NOTES FOR CODE 33477

- Diagnostic RHC and diagnostic angiography codes….should not be used with 33477 to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TPVI.
2. Pulmonary conduit angiography for guidance of TPVI, or
3. RHC for hemodynamic measurements before, during, and after TVPI for guidance of TVPI. ◀

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Stony Brook Medicine NEW NOTES FOR CODE 33477

- Diagnostic right and left heart catheterization codes, diagnostic coronary angiography codes, and diagnostic pulmonary angiography codes may be reported with 33477, representing a separate and distinct services from TVPI, if:

1. No prior study is available and a full diagnostic study is performed, or
2. A prior study is available, but as documented in the medical record:
   a. There is inadequate visualization of the anatomy and/or pathology, or
   b. The patient's condition with respect to the clinical indication has changed since the prior study, or
   c. There is a clinical change during the procedure that requires new evaluation. ◀

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- Cardiovascular injection procedures for diagnostic angiography…are not typically performed at the same session as 33741(TAS). Although diagnostic angiography is typically performed during 33745 (TIS), target vessels and chambers are highly variable and, when performed for an evaluation separate and distinct from the shunt creation, may be reported separately. ◀

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- Codes 33745, 33746 are used to describe intra cardiac stent placement. Multiple stents placed in a single location may only be reported with a single code. When additional, different intracardiac locations are treated in the same session, 33746 may be reported. Codes 33746, 33746 include all balloon angioplasty(ies) performed in the target lesion, including any pre-dilation (whether performed as a primary or secondary dilation) , post-dilation following stent placement, or use of larger/smaller balloon to achieve therapeutic result. Angioplasty in a sperate and distinct intracardiac lesion may be reported separately. Use 33746 in conjunction with 33745. ◀

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- Diagnostic left and right heart catheterization codes…should not be used in conjunction with 33741, 33745 to report:

1. Fluoroscopic guidance for the intervention, or
2. Limited hemodynamic and angiographic data used solely for the purposes of accomplishing the intervention (eg, measurement of atrial pressures before and after septostomy, atrial injections to determine appropriate catheter position. ◀

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Stony Brook Medicine

NEW NOTES FOR CARDIAC SHUNTING PROCEDURES 33741-33746

- Diagnostic left and right heart catheterization…performed at the same session as 33741 may be reported separately if:

1. No prior study is available, or
2. A prior study is available, but as documented in the medical record:
   a. There is inadequate visualization of the anatomy and/or pathology, or
   b. The patient's condition with respect to the clinical indiation has changed since the prior study, or
   c. There is clinical change during the procedure that requires more thorough evaluation.

For same-session diagnostic cardia angiography for an evaluation separate and distinct from 33741 or 33745 the appropriate contrast injection(s) performed…may be reported. ◀

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Stony Brook Medicine

NEW CODES FOR ENDOVASCULAR REPAIR OF PULMONARY ARTERY STENOSIS BY STENT

- 33900: Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral.
  - 33901 normal native connections, bilateral
  - 33902 abnormal connections, unilateral
  - 33903 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).
  - (Use 33904 in conjunction with 33900, 33901, 33902, 33903) ◀

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Stony Brook Medicine

NEW NOTES FOR ENDOVASCULAR REPAIR OF PULMONARY ARTERY STENOSIS WITH STENT 33900-33904

- …via normal native connections, defined as superior vena cava/inferior vena cava to right atrium, then right ventricle, then pulmonary arteries.

33902-33903 describe stent placement within the pulmonary arteries, ductus arteriosis, or within a surgical shunt, via abnormal connections or through post-surgical shunts (eg, Blalock-Taussig shunt, Sano shunt, or post Glenn or Fontan procedures). ◀

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- Codes 33900-33904 include vascular access and all catheter and guidewire manipulation, fluoroscopy to guide the intervention, any post-diagnostic angiography for roadmapping purposes and post-implant evaluation, stent positioning, and balloon inflation for stent delivery, and radiologic supervision and interpretation of the intervention.

Angiography at the same session, as part of a diagnostic cardiac catheterization, may be reported with the appropriate codes from the Radiology or Medicine/Cardiovascular/Cardiac Catheterization/Injection Procedures sections. ◀

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- Diagnostic cardiac catheterization and diagnostic angiography codes…should **not** be used with 33900-33904 to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TPVI,
2. Pulmonary conduit angiography for guidance of TPVI, or
3. RHC for hemodynamic measurements before, during, and after TPVI for guidance of TPVI. ◀

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- Diagnostic right and left heart catheterization codes…diagnostic coronary angiography codes…and diagnostic angiography codes… may be separately reported in conjunction with 33900-33904, representing separate and distinct services from pulmonary artery revascularization, if:

1. No prior study is available, and a full diagnostic study is performed, or
2. A prior study is available, but as documented in the medical record:
   a. There is inadequate visualization of the anatomy and/or pathophysiology, or
   b. The patient's condition with respect to the clinical indication has changed since the prior study, or
   c. There is a clinical change during the procedure that requires new evaluation. ◀

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Stony Brook Medicine

NEW NOTES FOR ENDOVASCULAR REPAIR OF PULMONARY ARTERY STENOSIS WITH STENT 33900-33904

- Do not report 33900-33904 in conjunction with the following for catheterization and angiography services intrinsic to the procedure:

76000	93460
93451	93461
93452	93563
93453	93564
93454	93565
93455	93566
93456	93567
93457	93568
93458	93593
93459	93594
	93596
	93597
	93598

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Stony Brook Medicine

NEW NOTES FOR ENDOVASCULAR REPAIR OF PULMONARY ARTERY STENOSIS WITH STENT 33900-33904

- Balloon angioplasty (92997, 92998) within the same target lesion as stent implant, either before or after stent deployment, is not separately reported. ◀
- For balloon angioplasty at the same session as 33900-33904, but for a distinct lesion or in a different artery, see 92997, 92998. ◀
- To report percutaneous pulmonary artery revascularization by stent placement in conjunction with diagnostic congenital cardiac catheterization, see 33900-33904. ◀
- For transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, see 33745, 33746. ◀

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Stony Brook Medicine

NEW NOTES FOR ECMO/ECLS SERVICES

- Services directly related to the cannulation, initiation, management, and discontinuation of the ECMO/ECLS circuit and parameters (33946-33949) are distinct from the daily overall management of the patient. The daily overall management of the patient is a factor that will vary greatly depending on the patient's age, disease process, and condition. Daily overall management of the patient may be separately reported using the relevant hospital inpatient or observation care services…or critical care or intensive care evaluation and management codes… ◀

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Stony Brook Medicine NEW NOTES FOR ECMO/ECLS SERVICES

- If the same physician provides any or all of the services for patient a patient on an ECMO/ECLS circuit, they may report the appropriate codes for the services they performed which may include codes for the cannula(e) insertion (33951-33956), ECMO/ECLS initiation (33946 or 33947) and overall patient management… ◀

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Stony Brook Medicine CODE REVISION 35883

▲ 35883: Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (e.g. ~~Dacron~~ polyester, ePTFE, bovine pericardium).

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Stony Brook Medicine NEW CPT CODES 36836, 36837

- #36836: Percutaneous arteriovenous fistula creation, upper extremity, single access of both 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.
- #36837 two separate access sites

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- The artery and vein are approximated and then energy (e.g. thermal) is applied to establish the fistulous communication between the two vessels. Fistula maturation procedures promote blood flow through the newly created fistula by augmentation (eg, angioplasty) or redirection (e.g. coil embolization of collateral pathways) of blood flow. ◀

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- (For arteriovenous fistula creation via an open approach, see 36800, 36810, 36815, 36818, 36819, 36820, 36821) ◀
- (For percutaneous arteriovenous fistula creation in any other location other than the upper extremity, use 37799). ◀

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- Do not report 36836, 36837 in conjunction with:

36005	36837	37236	75822
36140	36901	37238	75894
36215	36902	37241	75898
36216	36903	37242	76937
36217	36904	37246	77001
36218	36905	37248	
36245	36906	37252	
36246	36907	75710	
36247	36908	75716	
	36909	75820	

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- If a separately E/M service is performed on the same date of service, the appropriate E/M service code, including office or other outpatient services, established…hospital inpatient or observation care services… and inpatient neonatal and pediatric critical care…may be reported using modifier 25 in addition to codes 38240, 38242, or 38243. Post-transplant infusion management of adverse reactions is reported separately using the appropriate E/M, prolonged service or critical care code(s). ◀

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- In accordance with place of service and facility reporting guidelines, the fluid used to administer the cells and other infusions for incidental hydration (eg 96360, 96361) are not separately reportable. Similarly, infusion(s) of any medication(s) concurrently with the transplant infusion are not separately reportable. However, hydration or administration of medications (eg antibiotics, narcotics) unrelated to the transplant are separately reportable using modifier 59. ◀

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Digestive System

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Stony Brook Medicine NEW CODES 43290 & 43291

- #43290 EGD with deployment of intragastric bariatric balloon
- #43291 EGD with removal of intragastric bariatric balloon(s)

➢ (Do not report 43290, 43291 in conjunction with 43197, 43198, 43241*, 43235, 43247 ◀

*43241 only applicable to 43290

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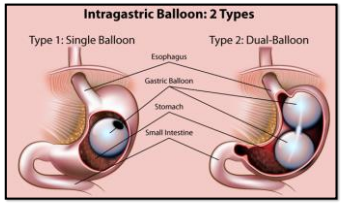
Stony Brook Medicine NEW CODES 43290 & 43291



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56

Stony Brook Medicine NEW NOTES UNDER ERCP

➢ (For removal of biliary drainage catheter not requiring fluoroscopic guidance, see E/M services and report the appropriate level of service provided… ◀

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Stony Brook Medicine NEW CPT CODES FOR HERNIA REPAIR

- Codes 49560, 49561, 49565, 49566, 49568, 49570, 49572, 49580, 49582, 49585, 49587, 4959, 49652, 49653, 49654, 49655, 49656, 49657 deleted.
- 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 3cm, reducible
  - 49592 less than 3cm, incarcerated or strangulated
  - 49593 3cm-10cm, reducible
  - 49594 3cm-10cm, incarcerated or strangulated
  - 49595 greater than 10cm, reducible
  - 49596 greater than 10cm, incarcerated or strangulated

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Stony Brook Medicine NEW CPT CODES FOR HERNIA REPAIR

- #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 3cm reducible
  - #49614 less than 3cm, incarcerated or strangulated
  - #49615 3cm to 10cm, reducible
  - #49616 3cm to 10cm, incarcerated or strangulated
  - #49617 greater than 10cm, reducible
  - #49618 greater than 10cm, incarcerated or strangulated

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Stony Brook Medicine NEW CPT CODES FOR HERNIA REPAIR

- #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

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- #+49623: Removal of total or near total non-infected mesh or other prosthesis at the same 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)
- ➢ (Use 49623 in conjunction with 49591-49622) ◀
- ➢ (For removal of infected mesh, use code 11008) ◀

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- ➢ …Codes 49591-49618 are reported only once, based on the total defect size for one or more anterior abdominal wall hernia(s), measured as the maximal craniocaudal or transverse distance between the outer margins of all defects repaired…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). ◀

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- ➢ Inguinal, femoral, lumbar, omphalocele, and/or parastomal hernia repair may be separately reported when performed at the same operative session as anterior abdominal hernia repair by appending modifier 59, as appropriate. ◀

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Stony Brook Medicine

NEW NOTES RELATED TO HERNIA REPAIRS

- (49491-49557, 49600, 49605, 49606, 49610, 49611, 49650, 49651 are unilateral procedures. For bilateral procedure, use modifier 50) ◀
- (Do not report modifier 50 in conjunction with 49591-49622) ◀

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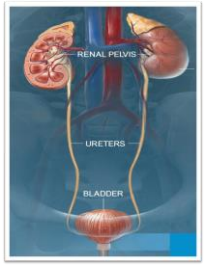
Stony Brook Medicine

Urinary System



65

Stony Brook Medicine

NEW NOTES NEPHROLITHOTOMY AND PYELOLITHOTOMY

- Nephrolithotomy is the surgical removal of stones from the kidney, and pyelolithotomy is the surgical removal of sones from the renal pelvis. This section of the guidelines referes to the removal of stones from the kidney or renal pelvis using a percutaneous antegrade approach. Breaking and removing stones is sperate from accessing the kidney (ie, 50040, 50432, 50433, 52334), accessing the kidney with dilation of the tract to accommodate an endoscope used in an endourologic procedure (ie, 50437), or dilation of a previously established tract to accommodate an endoscope used in an endourologic procedure (ie, 50436)

These procedures include antegrade removal of stones in the calyces, renal pelvis, and/or ureter with antegrade placement of catheters, stents, and tubes but do not include the retrograde placement of catheters, stents and tubes. ◀

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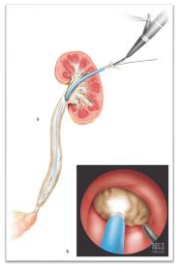
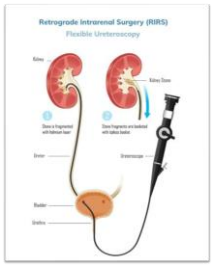
Stony Brook Medicine

NEW NOTES NEPHROLITHOTOMY AND PYELOLITHOTOMY





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Stony Brook Medicine

REVISION OF CODES 50080 & 50081

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

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Stony Brook Medicine

REVISION OF CODES 50080 & 50081

- (50080, 50081 may only be reported once per side. For bilateral procedure, report 50080, 50081 with modifier 50) ◀
- Do not report 50080, 50081 in conjunction with 50430, 50431, 50433, 50434, 50435, if performed on the same side) ◀
- (For establishment of nephrostomy without nephrolithotomy, see 50040, 50432, 50433, 52334) ◀
- For dilation of an existing percutaneous access for an endourologic procedure, use 50436) ◀

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Stony Brook Medicine

REVISION OF CODES 50080 & 50081

- (For dilation of an existing percutaneous access for an endourologic procedure with new access into the collecting system, use 50437; for additional new access into the kidney, use 50437 for each new access that is dilated for an endourologic procedure) ◀
- (For removal of stone without lithotripsy, use 50561) ◀
- (For cystourethroscopy with insertion of ureteral guidewire through kidney to establish a percutaneous nephrostomy, retrograde, use 52334) ◀

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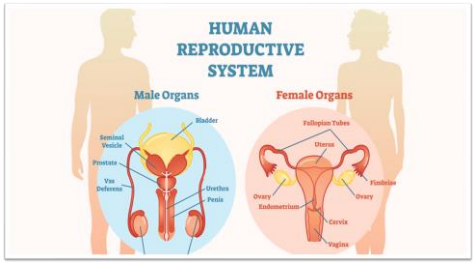

https://www.niehs.nih.gov/health/assets/images/reproductive_health_og.jpg

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Stony Brook Medicine

NEW CODE 55867

- 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.
  - (For open subtotal prostatectomy, see 55821, 55831) ◀

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- The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care. Pregnancy confirmation during a problem-oriented or preventative visit is not considered as part of the antepartum care and should be reported using the appropriate E/M code….for that visit. ◀

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- Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. When reporting delivery only services (59409, 59514, 59612, 59620), report inpatient post delivery management and discharge services using the E/M service codes…

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- …Delivery and postpartum services (59410, 59515, 59614, 59622) include delivery services and all inpatient and outpatient postpartum services. Medical complications of pregnancy (e.g. cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, preterm labor, premature rupture of membranes, trauma) and medical problems complicating labor and delivery management may require additional resources and may be reported separately. ◀

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Stony Brook Medicine

Nervous System

https://www.regionalneurological.com/wp-content/uploads/2020/08/Regional-Neurological_Parts-of-the-Nervous-System.jpeg

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- Imaging guidance and localization may be reported separately for 64400, 64405, 64408, 64420, 64421, 64425, 64430, 64435, 64449, 64450.

Imaging guidance and any injection of contrast are inclusive components of 64415, 64416, 64417, 64445, 64446, 64447, 64448, 64451, 64454. ◀

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▲64415: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed.
- (Do not report 64415 in conjunction with 76942, 77002, 77003) ◀

▲64416: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement), including imaging, when performed.
- (Do not report 64416 in conjunction with 01996, 76942, 77002, 77003) ◀

▲64417: Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed.
- (Do not report 64417 in conjunction with 76942, 77002, 77003) ◀

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REVISED CODES INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC

- 64445: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed
  - (Do not report 64445 in conjunction with 76942, 77002, 77003)
- 64446: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed.
  - (Do not report 64446 in conjunction with 01996, 76942, 77002, 77003)
- 64447: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed.
  - (Do not report 64447 in conjunction with 01996, 76942, 77002, 77003)
- 64448: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed.
  - (Do not report 64448 in conjunction with 01996, 76942, 77002, 77003)

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NEW NOTES INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC

- Codes 64490-64495 describe the introduction/injection of a diagnostic or therapeutic agent into the paravertebral facet joint or into the nerves that innervate that joint by level.
- Facet joints are paired joints with one pair at each vertebral level. Imaging guidance and localization are required for the performance of paravertebral facet joint injection described by 64490-64495.
- If imaging is not used, report 20552, 20553.
- If ultrasound guidance is used, report 0213T, 0214T, 0215T, 0216T, 0217T, 0218T.

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Stony Brook Medicine

NEW NOTES INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC

- When determining a level, count the number of facet joints injected, not the number of nerves injected. Therefore, if multiple nerves at the same facet joint are injected, it would be considered a single level. The add-on codes are reported when second, third, or additional levels are injected during the same session.
- When the procedure is performed bilaterally at the same level, report one unit of the primary code with a modifier 50.

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- When the procedure is performed on the left side at one level and the right side at a different level in the same region, report one unit of the primary procedure and one unit of the add-on code.
- When the procedure is performed bilaterally at one level and unilaterally at a different level(s), report one unit of the primary procedure for each level and append modifier 50 for the bilateral procedure.
- If the procedure is performed unilaterally at different levels, report one unit of the primary procedure and the appropriate add-on code(s). ◀

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- (For unilateral paravertebral facet injection of the T12-L1 and L1-L2 levels or nerves innervating that joint, use 64490 and 64494 once) ◀
- For bilateral paravertebral facet injection of the T12-L1 and L1-L2 levels or nerves innervating that joint, use 64490 with a modifier 50 once, and 64494 twice) ◀

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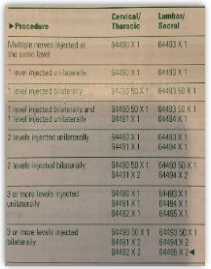

▶ Procedure	Cervical/ Thoracic	Lumbar/ Sacral
Multiple nerves injected at the same level	64490 X 1	64493 X 1
1 level injected unilaterally	64490 X 1	64493 X 1
1 level injected bilaterally	64490 50 X 1	64493 50 X 1
1 level injected bilaterally and 1 level injected unilaterally	64490 50 X 1 64491 X 1	64493 50 X 1 64494 X 1
2 levels injected unilaterally	64490 X 1 64491 X 1	64493 X 1 64494 X 1
2 levels injected bilaterally	64490 50 X 1 64491 X 2	64493 50 X 1 64494 X 2
3 or more levels injected unilaterally	64490 X 1 64491 X 1 64492 X 1	64493 X 1 64494 X 1 64495 X 1
3 or more levels injected bilaterally	64490 50 X 1 64491 X 2 64492 X 2	64493 50 X 1 64494 X 2 64495 X 2 ◀

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Stony Brook Medicine

NEW NOTES INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC

+64494: *Facet injection with imaging guidance, lumbar or sacral;* second level (List separately in addition to code for primary procedure).

➢ (Use 64494 in conjunction with 64490, 64493) ◀

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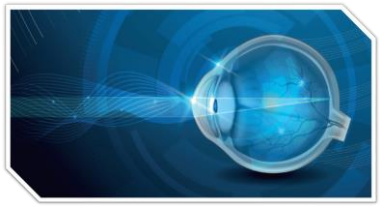
Stony Brook Medicine

Eye and Ocular Adnexa



https://images.ctfassets.net/u4vv676b8z52/1yqxGX9xjos7rZ7Ft1PHMf/28b686e715ceadbb40eb0caa571a53f3/blue-eye-3d-1200x630.jpg?fm=jpg&q=80

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Stony Brook Medicine

REVISION CODES 66174 & 66175

▲66174: Transluminal dilation of aqueous outflow canal (e.g. canaloplasty); without retention of device or stent.

▲66175 with retention of device or stent.

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Stony Brook Medicine

Auditory System

https://media.sciencephoto.com/image/c0076826/800wm

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Stony Brook Medicine

NEW NOTES UNDER REMOVAL

69209: Removal impacted cerumen using irrigation/lavage, unilateral

69210 Removal impacted cerumen requiring instrumentation, unilateral.

- For cerumen removal that is not impacted, see E/M service code…◀

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Stony Brook Medicine

NEW AND REVISED CODES/NOTES FOR OSSEOINTEGRATED IMPLANTS

- The following codes are for implantation of an osseointegrated implant into the skull. These devices treat hearing loss through surgical placement of an abutment or device into the skull that facilitates transduction of acoustic energy to be received by the better-hearing inner ear or both inner ears when the implant is coupled to a speech processor and vibratory element. This coupling may occur in a percutaneous or a transcutaneous fashion. Other middle ear and mastoid procedures (69501-69676) may be performed for different indications and may be reported separately, when performed. ◀

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#69714: Implantation, osseointegrated implant, skull;…

- #69716: 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 deep bone 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.

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- #69717: ~~Revision or~~Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor.
  - #69719: 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.
    - #69730: with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a boney defect great than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex.

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- #69726: Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor.
  - (To report partial removal of the device (ie, abutment only), use appropriate evaluation and management code)
  - #69727: with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect of less than 100 sq mm surface area of bone deep to the outer cranial cortex.
    - #69728: 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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Stony Brook Medicine

Medicine Updates

https://st.depositphotos.com/2105931/3058/v/950/depositphotos_30589037-stock-illustration-set-of-medical-symbols.jpg

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Stony Brook Medicine "NEW" COVID VACCINE CODES AND NOTES

- COVID vaccine codes have been released periodically over the course of the past couple of years, in between book publishing dates.
- "New" notes and codes apply to codes that already exist and are in use.
- Appendix Q in CPT is a great resource for all COVID vaccine related information.
- See weblink below for specific release and effective dates of codes.

https://www.ama-assn.org/system/files/vaccine-long-descriptors.pdf

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Stony Brook Medicine NEW CARDIOVASCULAR MEDICINE NOTES

- Notes applicable to 92920-92944
  - ➢ Describe percutaneous revascularization services performed for occlusive disease of the coronary vessels (major coronary arteries, artery branches, or coronary artery bypass grafts).
  - ❖ These PCI codes are built on progressive hierarchies with more intensive services inclusive of the lesser intensive services…

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- These PCI codes all include the work of accessing and selectively catheterizing the vessel, traversing the lesion, radiological supervision and interpretation directly related to the intervention(s) performed, closure of the arteriotomy when performed through the access sheath, and imaging performed to document the completion of the intervention in addition to the intervention(s) performed.
  - These codes include angioplasty (eg, balloon, cutting balloon, wired balloons, cryoplasty), atherectomy (eg, directional, rotational, laser), and stenting (eg, balloon expandable, self-expanding, BMS, DES, covered)…

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- Each code in this family includes balloon angioplasty, when performed. Diagnostic coronary angiography may be reported separately under specific circumstances. Percutaneous transluminal coronary lithotripsy may be reported using 0715T in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975, as appropriate. ◀

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- Codes 92973, 92974, 92978, 92979, 93571, 93572, and 0715T, are add-on codes for reporting procedures performed in addition to coronary bypass graft diagnostic and interventional services, unless included in the base code. Non-mechanical aspiration thrombectomy is not reported with 92973, and is included in the PCS code for AMI (92941), when performed. ◀

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Stony Brook Medicine NEW CARDIAC CATHETERIZATION NOTES

- Very closely mirrors the new notes in the pulmonary shunting/stenting section in the 3XXXX range.
- ➢ For right ventricular or right atrial angiography performed in conjunction with RHC for non-congenital disease…or for the evaluation of congenital heart defects…, use 93566…
- ❖ For reporting purposes, angiography of the morphologic right ventricle or morphologic right atrium is report ed with 93566, whether these structures are in the standard prepulmonic position or in a systemic (subaortic) position…

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Stony Brook Medicine NEW CARDIAC CATHETERIZATION NOTES

- ➢ LHC performed for non-congenital heart disease…includes left ventriculography, when performed.
- ❖ For reporting purposes, angiography of the morphologic left ventricle or morphologic left atrium is reported with 93565, whether these structures are in the standard systemic (subaortic) position or in a prepulmonic position.
- ❖ Do not repot 96365 in conjunction with: 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461.

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Stony Brook Medicine NEW CARDIAC CATHETERIZATION NOTES

- ➢ For cardiac catheterization performed for the evaluation of congenital heart defects, left ventriculography is separately reported with 93565.
- ❖ For cardiac catheterization for both congenital and non-congenital heart defects, supravalvular aortography is reported with 93567.
- ❖ For cardiac catheterization for both congenital and non-congenital heart defects, pulmonary arterial angiography is reported with the appropriate pulmonary angiography code(s),…plus the appropriate cardiac catheterization code.

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- When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital heart disease…see 93563, -93569, 93573-93575.
  - Injection procedures 93563—93569, 93573-93575 represent separate identifiable services and ma be reported in conjunction with one another when appropriate.
  - Codes 93563-93569, 93573-93575 include imaging supervision, interpretation, and report.

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- For angiography of noncoronary and non-pulmonary arteries and veins, performed as a distinct service, use appropriate codes from the Radiology section and the Vascular Injection Procedures subsection in the Surgery/Cardiovascular System section.

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- For nonselective pulmonary arterial angiography, use 93568. For selective unilateral or bilateral pulmonary arterial angiography, see 93569, 93573.
  - For selective venous angiography, use 93574 for each distinct vessel.
  - For selective pulmonary arterial angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its system branches, use 93575 for each distinct vessel.

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Stony Brook Medicine NEW CARDIAC CATHETERIZATION NOTES

- Injection procedures 93574, 93575 represent selective venous and arterial angiography, respectively, for each distinct vessel.
  - Codes 93574, 93575 require evaluation of a distinct, named vessel (eg, right upper pulmonary vein, left lower pulmonary vein, left pulmonary artery via Blalock-Taussig shunt access, MAPCA vessel #1 from underside of aortic arch) and may be reported for each distinct, named vessel evaluated.
  - Selective pulmonary angiography codes for cardiac catheterization…include selective angiographic catheter positioning, injection, and radiologic supervision and interpretation.

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Stony Brook Medicine NEW CARDIAC CATHETERIZATION NOTES

- Adjunctive hemodynamic assessments: when cardiac catheterization is combined with pharmacologic agent administration with the specific purpose of repeating hemodynamic measurements to evaluate hemodynamic response, use 93463 in conjunction with 93451-93453 and 93456-93461, 93593-93597.
  - Do not report 93463 for intracoronary administration of pharmacologic agents during PCI procedures, during intracoronary assessment of coronary pressure, flow or resistance, or during intracoronary imaging procedures.
  - Do not report 93463 in conjunction with 92920-92944, 92975, 92977. ◀

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Stony Brook Medicine NEW AND REVISED CODES FOR PULMONARY ANGIOGRAPHY

▲ +93568: *Injection procedure during cardiac catheterization;* for nonselective arterial angiography (List separately in addition to code for primary procedure)

- (Use 93568 in conjunction with: 33361-33366, 33418, 33419, 33477, 33741, 33745, 33894, 33895, 33900-33904, 37187, 37188, 37236-37238, 37246, 37248, 92997, 92998, 93451, 93453, 93456, 93457, 93460, 93461, 93580, 93581-93583, 93593-93597) ◀
- (For selective unilateral or bilateral pulmonary arterial angiography, use 93569, 93573, which include catheter placement, injection, and radiologic supervision and interpretation) ◀

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- **+**93569: *Injection procedure during cardiac catheterization;* for selective arterial angiography, unilateral (List separately in addition to code for primary procedure)
- **#+**93573: *Injection procedure during cardiac catheterization;* for selective pulmonary arterial angiography, bilateral (List separately in addition to code for primary procedure)

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- **#+**93574: *Injection procedure during cardiac catheterization;* for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization (List separately in addition to code for primary procedure)
- **#+**93575: *Injection procedure during cardiac catheterization;* for selective pulmonary angiography of MAPCAs arising off the aorta or its systemic branches, during cardiac catheterization for congenital heart defects, each distinct vessel (List separately in addition to primary procedure)

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- 93569, 93573-93575 include the selective introduction and position of the angiographic catheter, injection, and radiologic supervision and interpretation.

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Stony Brook Medicine

NEW NOTES ASSOCIATED WITH UPDATED E/M GUIDELINES

- Peripheral Arterial Disease Rehabilitation 93668
- Pulmonary Diagnostic Testing, Rehabilitation, and Therapies 94010-94799
- Allergy and Clinical Immunology 95004-95199
- Injections/Infusions 96360-96549
  - Also a new note that indicates that certain injection/infusion codes are meant for facility only and should not be assigned by MD
- Acupuncture 97810, 97811, 97813, 97814
- Osteopathic Manipulative Treatment 98925-98929
- Chiropractic Manipulative Treatment 98940-98943
- Education and Training for Patient Self-Management 98960-98962
- Remote Therapeutic Monitoring Treatment Management Services 98980-98981
  - Also has new notes regarding time spent, documentation requirements, and other CPT codes that this code range can be used with.

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Stony Brook Medicine

Category III Codes

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Stony Brook Medicine

DELETED CODES

- Codes 0312T-0317T have been deleted.
- For laparoscopic implantation, revision, replacement or removal of vagus nerve blocking neurostimulator electrode array and/or pulse generator at the EG junction, use 64999.

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- 0470T, 0471T have been deleted.
  - For optical coherence tomography (OCT) for microstructural and morphological imaging of skin, use 96999.
- 0487T has been deleted
  - For transvaginal biomechanical mapping, use 58999.
- 0491T, 0492T has been deleted
  - For non-contact full-field and fractional ablative laser treatment of an open wound, use 17999.

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Stony Brook Medicine

- 0493T has been deleted
  - For transcutaneous oxyhemoglobin measurement in a lower extremity wound by near-infrared spectroscopy, use 93998

➢ Near-infrared spectroscopy is used to measure cutaneous vascular perfusion. Codes 0640T-0642T describe non-contact near-infrared spectroscopy of skin flaps or wounds for measurement of cutaneous vascular perfusion that does not require direct contact of the spectrometer sensors with the patient's skin. ◀

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- 0497T and 0498T have been deleted
  - For in-office connection or review and interpretation of an external patient-activated electrocardiographic rhythm-derived event recorder without 24-hour attended monitoring, use 93799.
- 0499T has been deleted
  - For cystourethroscopy with urethral therapeutic drug delivery, use 53899
- Code 0514T has been deleted and not replaced.
- 0702T and 0703T have been deleted
  - For remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program, use 98978.

AMA CPT 2023 pg. 898, 900, & 920-921

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Stony Brook Medicine

NEW CATEGORY III CODES

HCPCS Code	Short Descriptor	SI
0715T	Percutaneous transluminal coronary lithotripsy	N
0716T	Cardiac acoustic waveform recording	Q1
0717T	ADRC for partial thickness rotator cuff tear	E1
0718T	ADRC injection into supraspinatus tendon	E1
0719T	Posterior vertebral joint replacement, lumbar spine, single segment	E1
0720T	Percutaneous electrical nerve field stimulation	S
0721T	Quan ct tiss charac w/o ct	S
0722T	Quan ct tiss charac w/ct	S
0723T	Qmrcp w/o dx mri sm anat ses	S
0724T	Qmrcp w/dx mri same anatomy	S
0725T	Vestibular dev implt uni	E1
0726T	Rmvl implt vstibular dev uni	E1
0727T	Rmvl&rplcmt implt vstblr dev	E1
0728T	Dx alys vstblr implt uni 1st	E1
0729T	Dx alys vstblr implt uni sbq	E1
0730T	Trabeculotomy slr w/oct gdn	E1
0731T	Augmnt ai-based facial phenotype analysis	S
0732T	Immnttx admn electroporatn im	E1
0735T	Prep tum cav with palcement of radiation therapy applicator for IORT concurrent with carniotomy	N

HCPCS Code	Short Descriptor	SI
0736T	Colonic lavage 35+l water	S
0737T	Xenograft implt j artclr surf	E1
0738T	Trtment pln mag fld ablt j prst8	E1
0739T	Ablt j mal prst8 mag fld ndct	E1
0740T	Rem auton alg nsln cal setup	S
0741T	Rem auton alg nsln data coll	S
0742T	Aqmbf spect xers/strs & rest	N
0743T	Bone str & fx rsk vrt fx asumt	E1
0744T	Inj bioprostc vlv fem vn	J1
0745T	Car ablt rad arr n-invas loc	E1
0746T	Car ablt rad arr cnv loc map	E1
0747T	Car ablt rad arrhyt dlvr rad	E1
0748T	Njx stm cl prdct anl sft tis	E1
0749T	B1 str&fx rsk assmt dxr-bmd	E1
0750T	B1 str&fx rsk asmt dxrbmd1vw	E1

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NEW CATEGORY III CODES

HCPCS Code	Short Descriptor	SI
0751T	Dgtz gls mcrscp sld level ii	N
0752T	Dgtz gls mcrscp sld lvl iii	N
0753T	Dgtz gls mcrscp sld level iv	N
0754T	Dgtz gls mcrscp sld level v	N
0755T	Dgtz gls mcrscp sld level vi	N
0756T	Dgtz gls mcrscp sld spc grpi	N
0757T	Dgtz gls mcrscp sl spc grpii	N
0758T	Dgtz gls mcrscp sl spc hchem	N
0759T	Dgtz gls mcrscp sl sp grpiii	N
0760T	Dgtz gls mcrscp sl imm 1st	N
0761T	Dgtz gls mcrscp sl imm ea 1	N
0762T	Dgtz gls mcrscp sl imm ea m	N
0763T	Dgtz gls mcrscp mphmtrc alys	N
0764T	Asstv alg ecg rsk asmt cncrt	E1
0765T	Asstv alg ecg rsk asmt prev	E1
0766T	Tc mag stimj pn 1st tx 1nrv	Q1
0767T	Tc mag stimj pn 1st tx ea	N
0768T	Tc mag stimj pn sbsq tx 1nrv	Q1
0769T	Tc mag stimj pn sbsq tx ea	N

HCPCS Code	Short Descriptor	SI
0770T	Vr technology assist therapy	E1
0771T	Vr px dissoc svc sm phy 1st	E1
0772T	Vr px dissoc svc sm phy ea	E1
0773T	Vr px dissoc svc oth phy 1st	E1
0774T	Vr px dissoc svc oth phy ea	E1
0775T	Arthrd sj jt prq iartic impl	J1
0776T	Ther indctj ntrabrn hypthrm	E1
0777T	R-t prs sensing edrl gdn sys	N
0778T	Smmg cncrnt appl imu snr	Q1
0779T	Gi myoelectrical actv study	Q1
0780T	Instlj fecal microbiota ssp	B
0781T	Bmchsic rf dstrj pulm nrv bi	E1
0782T	Bmchsc rf dstrj plm nrv uni	E1
0783T	Tc auricul r neurostimulation	S

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- +0715T: Percutaneous transluminal coronary angioplasty (list separately in addition to code for primary procedure
  - Use in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975
  - Status N

AMA CPT 2023 pg. 921

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- 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
  - Do not report in conjunction with 15769, 15771, 15772, 15773,15774, 15876, 15877, 15878, 15879, 20610, 20611, 76942, 77002, 0232T, 0481T, 0489T, 0565T.
- 0718T: Injection into supraspinatus tendon including ultrasound guidance, unilateral.
  - Do not report in conjunction with 20610, 20611, 76942, 77002, 0232T, 0481T, 0490T, 0566T.
- Both status E1

AMA CPT 2023 pg. 921

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- 0719T: Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment.
  - Do not report with 22840,63005, 63012, 63017, 63030, 63042, 63047, 63056, 7600, 76496.
  - Status E1

AMA CPT 2023 pg. 921-922

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Stony Brook Medicine VESTIBULAR IMPLANTS

- 0725T: Vestibular device implantation, unilateral.
  - Do not report with 69501, 69502, 69505, 69511, 69601, 69602, 69603, 69604
- 0726T: Removal of implanted vestibular device, unilateral.
  - Do not report with 69501, 69502, 69505, 69511, 69601, 69602, 69603, 69604
- 0727T: Removal and replacement of implanted vestibular device, unilateral
  - Do not report with 69501, 69502, 69505, 69511, 69601, 69602, 69603, 69604
  - For cochlear device implantation, with or without mastoidectomy, use 69930.
- 0728T: Diagnostic analysis of vestibular implant, unilateral; with initial programing.
- 0729T: "…"; with subsequent programing
- All Status E codes

AMA CPT 2023 pg. 922

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DIGITAL PATHOLOGY DIGITIZATION PROCEDURES

- Digital pathology is a dynamic, image-based environment that enables the acquisition, management, and interpretation of pathology information generated from digitized glass microscope slides.
- Glass microscope slides are scanned by clinical staff and captured images (either in real-time or stored in a computer server or cloud-based digital image archival and communication system) are used for digital examination for pathologic diagnosis distinct from direct visualization through a microscope.
- Digitization of glass microscope slides enables remote examination by the pathologist and/or in conjunction with the use of artificial intelligence (AI) algorithms.

AMA CPT 2023 pg. 924

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Stony Brook Medicine

TRANSCUTANEOUS MAGNETIC STIMULATION FOR CHRONIC PAIN

- Codes 0766T-0769T describe transcutaneous magnetic stimulation that is performed to treat chronic nerve pain and provided by a physician or other qualified healthcare professional.
- The injured nerve is localized using magnetic stimulation at the time of initial treatment, the skin is marked (with photographic record) to facilitate rapid localization of the correct site for subsequent treatments, and the appropriate amplitude of magnetic stimulation is defined.

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Stony Brook Medicine

VIRTUAL REALITY

- Virtual reality (VR) technology may be integrated into multiple types of patient therapy as an adjunct to the base therapy. Code 0770T is an add-on code that represents the practice expense for the software used for the VR technology and may be reported for each session for which the VR technology is used
- VR technology is incorporated into the base therapy session and is used to enhance the training or teaching of a skill upon with the therapy is focused.

AMA CPT 2023 pg. 926

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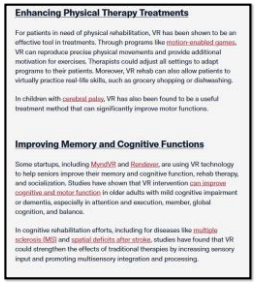

Enhancing Physical Therapy Treatments

For patients in need of physical rehabilitation, VR has been shown to be an effective tool in treatments. Through programs like motion-enabled games, VR can reproduce precise physical movements and provide additional motivation for exercises. Therapists could adjust all settings to adapt programs to their patients. Moreover, VR rehab can also allow patients to virtually practice real-life skills, such as grocery shopping or dishwashing.

In children with cerebral palsy, VR has also been found to be a useful treatment method that can significantly improve motor functions.

Improving Memory and Cognitive Functions

Some startups, including MyndVR and Rendever, are using VR technology to help seniors improve their memory and cognitive function, rehab therapy, and socialization. Studies have shown that VR intervention can improve cognitive and motor function in older adults with mild cognitive impairment or dementia, especially in attention and execution, member, global cognition, and balance.

In cognitive rehabilitation efforts, including for diseases like multiple sclerosis (MS) and spatial deficits after stroke, studies have found that VR could strengthen the effects of traditional therapies by increasing sensory input and promoting multisensory integration and processing.

https://www.uschamber.com/technology/how-virtual-reality-is-transforming-healthcare

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- VR procedural disassociation is a VR-based state of altered consciousness that supports and optimizes the patient's comfort, increases procedural tolerance, and decreases the patient's pain during the associated procedure.
- VR procedural dissociation establishes a computer-generated audio, visual, and proprioceptive immersive environment in which patient respond purposefully to verbal commands and stimuli, either alone or accompanied by light tactile stimulation.
- VR procedural dissociation does not involve interventions to maintain cardiovascular function, patent airway, or spontaneous ventilation.
- Codes 0771T-0774T.

AMA CPT 2023 pg. 926

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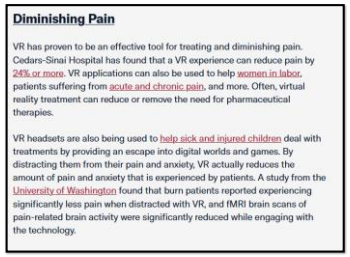

Diminishing Pain

VR has proven to be an effective tool for treating and diminishing pain. Cedars-Sinai Hospital has found that a VR experience can reduce pain by 24% or more. VR applications can also be used to help women in labor, patients suffering from acute and chronic pain, and more. Often, virtual reality treatment can reduce or remove the need for pharmaceutical therapies.

VR headsets are also being used to help sick and injured children deal with treatments by providing an escape into digital worlds and games. By distracting them from their pain and anxiety, VR actually reduces the amount of pain and anxiety that is experienced by patients. A study from the University of Washington found that burn patients reported experiencing significantly less pain when distracted with VR, and fMRI brain scans of pain-related brain activity were significantly reduced while engaging with the technology.

https://www.uschamber.com/technology/how-virtual-reality-is-transforming-healthcare

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OFFICE-BASED MEASUREMENT OF MECHANOMYOGRAPHY AND INERTIAL MEASUREMENT UNITS

- Code 0778T represents the measurement and recording of dynamic joint motion and muscle function that includes the incorporation of multiple inertial measurement unit (IMU) with concurrent surface mechomyography (sMMG) sensors.
- This is not a remote service and measurements are obtained in the office setting while the patient is physically present.

AMA CPT 2023 pg. 929

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Radiology

https://www.verywellhealth.com/thmb/YLgIKQ041MD5nReVy6h5WEPUCZ4=/3985x2499/filters:no_upscale().max_bytes(150000):strip_icc()/iStock-1223789376-c0e6750f4ae643dca0b53292ca062e3b.jpg

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Stony Brook Medicine

SUMMARY

- New notes under certain angiography codes 75710-75774
- New notes under certain venography codes 75820-75822
- New notes under certain transcatheter procedures 75894-75984
- New notes under ultrasonic guidance procedure codes **+**76937 and 76942
- New notes under certain Radiologic Guidance codes, **+**77002, **+**77003

AMA CPT 2023 pg. 517-570

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- Code 76882 represents a limited evaluation of a joint or focal evaluation of a structure(s) in any extremity other than a joint (eg, soft-tissue mass, fluid collection, or nerve(s)). Limited evaluation of a joint includes assessment of a specific anatomic structure(s) (e.g. joint space only (effusion) or tendon, muscle, and/or other soft-tissue structure(s) that surround the joint) that does not assess all of the required elements included in 76881. Code 76882 also requires permanently recorded images and a written report containing a description of each of the elements evaluated…

AMA CPT 2023 pg. 548-549

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- …Comprehensive evaluation of a nerve is defined as evaluation of the nerve throughout its course in an extremity. Documentation of the entire course of a nerve throughout the extremity includes the acquisition and permanent archive of cine clips and static images to demonstrate anatomy. ◀

AMA CPT 2023 pg. 548-549

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▲76882: Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s)(eg, joint space, periarticular tendon(s), muscle(s), nerve(s), other soft-tissue structure(s), or soft-tissue mass(es), real-time with image documentation.

- (Do not report 76882 in conjunction with 76883) ◀
- 76883: Ultrasound, nerve(s) and accompanying structures throughout the entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity.

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Evaluation & Management

https://image.freepik.com/free-vector/doctor-examining-patient-clinic-illustrated_23-2148856559.jpg

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Stony Brook Medicine SUMMARY

- Prior to 2023 the descriptors for the levels of service for many E/M codes continued to recognize seven components in code selection:

1. History
2. Examination
3. Medical Decision Making
4. Counseling
5. Coordination of Care
6. Nature of Presenting Problem
7. Time

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Stony Brook Medicine SUMMARY

- For 2023 the revisions expanded upon 2021 changes for certain outpatient services to all services, in which code selection is made on the basis of Medical Decision Making (MDM) or total time on the date of encounter.
- A medically appropriate history and/or examination is required where noted, but they are not used to select the level of E/M service.

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SUMMARY

- Reasoning for many of the changes were administrative simplification and to reduce the burden on physicians and other qualified healthcare professionals.

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OTHER CHANGES FOR 2023

- The observation inpatient and observation care services codes have been deleted and the services have been consolidated into the existing hospital care codes.
- The consultations code group has been retained with streamlined guidelines and a realignment of MDM levels.
- Emergency department services will continue to be measured using MDM as the key criterion for code selection.
- Nursing facility services have a revised set of guidelines, a new MDM criterion, and the annual nursing facility assessment code has been consolidated.
- Home and residence service changes have included the deletion of the domiciliary or rest home codes. In addition, these services have been merged with existing home visit codes.
- Prolonged services codes have been revised with the deletion of direct patient contact codes and the addition of a new code for the inpatient, observation, nursing facility service areas, and prolonged psychotherapy services.

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HOSPITAL INPATIENT & OBSERVATION CARE SERVICES

- Changes is in this service area resulted in the clarification of certain concepts such as “observation status” not requiring that the patient be located in a designated observation area.
- New reporting rules now permit separate E/M reporting for services provided when the patient is admitted to the hospital as an inpatient or observation status subsequent to an encounter in another site of service (ie, by using modifier 25).

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- The time element for selecting the appropriate code when total time is used rather than MDM has been revised.

Initial & Subsequent Hospital Inpatient and Observation Services		
Code	2022 E/M Code Times (minutes)	2023 E/M Time (minutes)
99221	30	40
99222	50	55
99223	70	75
99231	15	25
99232	25	35
99233	35	50

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- For 99221-99223 Initial:
  - The following codes are used to report the first hospital inpatient or observation status encounter with the patient

An initial service may be reported when the patient has not received any professional services from the physician or other QHP or another physician or other QHP of the exact same specialty and subspecialty who belongs to the same group practice during the stay. ◀

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- Consultation services are utilized across numerous care settings, including in:
  - The office or other outpatient setting, including the physician's office
  - A hospital inpatient/observation setting
  - A nursing facility
- Consultation services have been updated to include "other qualified healthcare professional" (QHP) as another group of professionals who may request a consultation or who may initiate diagnostic and/or therapeutic services at the same or subsequent visit.
- Time threshold changes here as well.
- Consultations initiated by patient or family member should be reported with other appropriate E/M services codes, such as the initial hospital or observation care codes or the nursing facility codes.

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Stony Brook Medicine CONSULTATIONS

- For 2023, the CPT guidelines do not specify who may document a consulting request in a patient's medical record. Similarly, new guideline language specifically states that the consultant's services are to be communicated to the physician or other QHP or other appropriate source by written report.
- It is important to note that when advanced practice nurse and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

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Stony Brook Medicine CONSULTATIONS

- If the documentation does not identify a request for consultation by the physician or other QHP, or other appropriate source and a written report on the consultation findings and recommendations back to the treating physician or other QHP or other appropriate source, then the requirements for consultation are not met.

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Stony Brook Medicine EMERGENCY DEPARTMENT SERVICES

- Code 99281 has been revised to decrease the level of service to align with the service of code 99211.
- In addition, the code descriptor for 99281 has been revised to specifically state that the level "may not require the presence of a physician or other QHP".
- As usual, time is not a factor for emergency E/M, just MDM.
- Both ED and critical care services may be reported on the same day, if the condition of the patient changes after the initiation of the ED services and critical care services are required and provided.
- It is important to clarify if physician convenience is directing the visit to the ED, rather than the need for ED care, so proper codes are reported.
  - If patient sent to the ED for MD convenience, the appropriate office or other outpatient services codes (99202-99215) should be reported.
- MDM levels for 99282 and 99283 have been revised downward.

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HOME OR RESIDENCE SERVICES

- The codes to report domiciliary, rest home, or home care plan oversight services have been moved to the Care Management Services subsection.
- The 2023 definition of “home” is unchanged.
- Additional clarity has been provided on locations that constitute a residence, for which the codes may be used. The additional locations include:
  - Assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), a custodial care facility, or a residential substance abuse treatment facility.
  - For services in an ICF for individuals with intellectual disabilities and services provided in a psychiatric residential treatment center, report the appropriate nursing facility services codes.
- Travel time is not included in the time factor of the E/M level.

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Anesthesia

https://www.crushpixel.com/big-static17/preview4/anesthesia-color-icon-medical-procedure-2585076.jpg

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https://sd.keepcalms.com/i/keep-calm-there-s-no-change.png

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Pathology & Lab

https://cdn.labmanager.com/assets/articleNo/23521/img/5015/11bf19af-3e36-4fe0-991c-0ec7e91f9f5e-mar18-ls-future-640x360.jpg

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Stony Brook Medicine SUMMARY

- New notes for Genomic Sequencing Procedures and other Molecular Multianalyte Assays
- New CPT codes under Microbiology
- New notes regarding corresponding new category III codes for surgical pathology.
- Many new PLA codes, with some revisions.
- New notes that reference new E/M guidelines.

AMA CPT 2023 pg. 571-714

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OPPS Updates

https://www.aha.org/sites/default/files/styles/900x400/public/2018-06/cms-nh-work-for-medicaid.jpg?itok=5tx450IO

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2023 PAYMENT RATES

- Overall increase of 3.8% for both Hospital Outpatient Department (HOPD) and Ambulatory Surgery Center (ASC)
- Continued 2% reduction for hospitals that do not meet quality reporting requirements
- Using claims data from 2021 with cost reports data from June 2019 (pre-pandemic)

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INPATIENT ONLY PROCEDURES

❖ 11 services removed

- +26332 –arthrodesis, posterior interbody, each additional
- 21141 –reconstruction midface, single piece
- 21142 –reconstruction midface, 2 pieces
- 21143 –reconstruction midface, 3 or more pieces
- 21194 –reconstruction of mandible
- 21196 –reconstruction of mandible with internal fixation
- 21255 –reconstruction of zygomatic arch
- 21347 –open treatment of nasomaxillary complex fracture
- 21366 –open treatment of fracture of malar area
- 21422 –open treatment of palatal fracture
- 47550 –biliary endoscopy, intraoperative

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INPATIENT ONLY PROCEDURES

❖8 services added

- 15778 –implantation of mesh for delayed closure
- +22860 –total disc arthroplasty, second interspace

❖New anterior abdominal hernia repair codes

- 49596 –initial, incarcerated, >10 cm
- 49616 –recurrent, incarcerated, 3-10 cm
- 49617 –recurrent, reducible, >10 cm
- 49618 –recurrent, incarcerated, >10 cm
- 49621 –parastomal, reducible
- 49622 –parastomal, incarcerated

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ASC COVERED PROCEDURES

- 4 procedures added
  - 19307 –Modified radical mastectomy
  - 37193 –Endovascular removal of intravascular vena cava filter
  - 38531 –Biopsy/excision inguinal lymph node(s)
  - 43774 –Laparoscopic removal of gastric restrictive device (Lap Band)

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ASC PAYMENT FOR NON-OPIOID PRODUCTS

- Separate payment for pain management products that function as supplies
- C9290 –Exparel–injection bupivacaine liposome
- J1097 –Omidiria–phenylephrine and ketorolac ophthalmic irrigation
- J1096 –Dextenza–dexamethasone, lacrimal ophthalmic insert
- C9089 –Xaracoll–bupivacaine, collagen-matrix implant
- C9144 –Posimir–injection bupivicaine

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340B DRUG PAYMENTS

- In light of Supreme Court decision in *American Hospital Association v. Becerra* -
  - For 2023 –default rate of ASP + 6%
  - Removing increase in CF from 2018 to implement in budget neutral manner
  - CMS is still evaluating how to apply to prior calendar years –look for proposed rule regarding 2018-2022 payments

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Stony Brook Medicine BEHAVIORAL HEALTH SERVICES

- Continue payment for behavioral health services furnished remotely by HOPD staff, including professionals who cannot bill under the Physician Fee Schedule (PFS)
- Provisions to begin 152 days after the PHE ends
- In-person visit within 6 months prior and 12 months after
- Waived if care by telehealth began during PHE or within 151-days after
- Audio-only communications if patient is unable to use, or does not consent to, audio-video

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Stony Brook Medicine BEHAVIORAL HEALTH SERVICES

- New Codes:
  - C7900 -Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 15-29 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service
  - C7901 –initial 30-60 minutes
  - +C7902 –each additional 15 minutes

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Stony Brook Medicine N95 MASKS

- Domestic NIOSH-Approved
- Reflect and offset additional costs in acquiring
- Paid biweekly as lump sum
- Reconciled in cost report
- Budget neutral –meaning no additional funds have been allocated

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TRANSITIONAL PASS-THROUGH PAYMENT

- Temporary additional payments for:
  - Current orphan drugs
  - Current drugs and biologicals used in cancer therapy
  - Current radiopharmaceutical drugs
- Payment made for 2-3 years
  - 32 drugs with expiring pass-through payments 12/31/22
  - 43 drugs with expiring pass-through payments in CY 2023
  - 49 drugs will continue to be paid as pass-through in CY 2023

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PAYMENTS FOR SOFTWARE AS A SERVICE (SAAS)

- Includes clinical decision support software, clinical risk modeling, computer-aided detection
- Must be FDA approved and have received a CPT code
- When possible, align with CPT codes –otherwise, assign C-codes
- Examples:
  - Liver MultiScan
  - OptellumLCP
  - Quantitative Magnetic Resonance Cholangiopancreatography

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DENTAL SERVICES

- Services billed with CPT 41899 –unlisted procedure, dentoalveolar structures –reassigned to APC 5871
- Clarification that payment will only be made for Medicare covered dental services –See Physician Final Rule and Medicare Benefit Policy Manual
  - Dental services that are an integral part of a covered primary procedure furnished by another physician treating the primary medical illness
  - Medicare payment precluded by statute for "care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth."
  - Medicare Administrative Contractor makes determination of coverage

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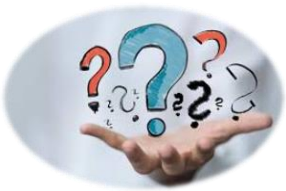
Questions?



https://lh3.googleusercontent.com/proxy/ChaJJ28DStuFP_ITcDKG_cp8BFSPOXk-pHPRZfDSB1EXeDrMmswx3ED0LMCF239YS57n8NSPFqntrnY-kjDhEHFeiNX5YKEl3BC0jluieTrlnVK6kxHnW3LRolDehFqCGyN-YWgdXrAqSNWp-dxRZDE1CkxfXkFKK1CUAQFR9iRu

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RESOURCES

- CMS OPPS Website
- American Medical Association. (2023). CPT 2023 Professional Edition. Chicago: American Medical Association.
- American Medical Association. (2023). CPT E/M Companion 2023. Chicago: American Medical Association.
- Huey, K. (2022, November 9). 2023 OPPS Updates. Wolters Kluwer.

Melissa.Minski@stonybrookmedicine.edu

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Extra Slides

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- Psychiatry services include diagnostic services, psychotherapy, and other services to an individual, family, or group. Patient condition, characteristics, or situational factors may require services described as being with interactive complexity. Services may be provided to a patient in crisis. Services are provided in all settings of care and psychiatry services codes are reported without regard to setting. Services may be provided by a physician or other qualified healthcare professional…

AMA CPT 2023 pg. 731-735

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- …Some psychiatry services may be reported with E/M services…or other services when performed. E/M services… may be reported for treatment of psychiatric conditions, rather than using psychiatry services codes, when appropriate.
  - If other procedures such as ECT or psychotherapy are rendered in addition to hospital evaluation and management services, these may be listed separately (e.g. hospital inpatient or observation services…plus ECT), or when psychotherapy is done, with appropriate code(s) defining psychotherapy services. ◀

AMA CPT 2023 pg. 731-735

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- Medical symptoms and disorders inform treatment choices of psychotherapeutic interventions, and data from therapeutic communication are used to evaluate the presence, type, and severity of medical symptoms and disorders. For the purposes of reporting, the medical and psychotherapeutic components of the service may be separately identified as follows:…

AMA CPT 2023 pg. 731-735

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NEW NOTES IN THE PSYCHIATRY MEDICINE SECTION

1. The type and level of E/M service is selected based on medical decision making.
2. Time spent on the activities of the E/M service is not included in the time used for reporting the psychotherapy service. Time may not be used as the basis for E/M code selection and prolonged services may not be reported when psychotherapy with E/M… are reported.
3. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service.◀

AMA CPT 2023 pg. 731-735

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NEW DIALYSIS NOTES

- Codes 90935, 90937 are reported to describe the hemodialysis procedure with all evaluation and management services related to the patient's renal disease on the day of the hemodialysis procedure. These codes are used for inpatient ESRD and non-ESRD procedure or for outpatient non-ESRD dialysis services.
  - Code 90935 is reported if only one evaluation of the patient is required related to that hemodialysis procedure.
  - Code 90937 is reported when patient re-evaluation(s) is required during a hemodialysis procedure…

AMA CPT 2023 pg. 736-737

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NEW DIALYSIS NOTES

- …Use modifier 25 with evaluation and management codes, including new or established patient office or other outpatient services,... office or other outpatient consultations,…hospital inpatient or observation care including admission and discharge services,…new or established patient emergency department services,…critical care services,…nursing facility services,…inpatient NICU services and pediatric and neonatal critical care services,…nursing facility services,…and home or residence services,…for separately identifiable service unrelated to the dialysis procedure or renal failure that cannot be rendered during the dialysis session. ◀

AMA CPT 2023 pg. 736-737

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NEW DIALYSIS NOTES

- Codes 90945, 90947 describe dialysis procedures other than hemodialysis (eg, peritoneal dialysis, hemofiltration or continuous renal replacement therapies), and all evaluation and management services related to the patient's renal disease on the day of the procedure.
  - Code 90945 is reported if only on evaluation of the patient is required related to that procedure.
  - Code 90947 is reported when patient re-evaluation(s) is required during a procedure…

AMA CPT 2023 pg. 736-737

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NEW DIALYSIS NOTES

- …Use modifier 25 with evaluation and management codes, including office or other outpatient services,…office or other outpatient consultations,…hospital inpatient or observation discharge services,…new or established patient emergency department services,…critical care services,…inpatient NICU services and pediatric and neonatal intensive are services and pediatric and neonatal critical care services,… and home or residence services…for separately identifiable services unrelated to the procedure or the renal failure that cannot be rendered during the dialysis session. ◀

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NEW AND REVISED OPHTHALMOLOGICAL MEDICINE CODES

92065: Orthoptic training; performed by a physician or other qualified healthcare professional.

- (Do not report 92065 in conjunction with 92066, 0687T, 0688T, when performed on the same day) ◀
  - 92066: orthoptic training; under supervision of a physician or other qualified healthcare professional
- (Do not report 92066 in conjunction with 92065, 0687T, 0688T, when performed on the same day) ◀

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NEW AND REVISED OPHTHALMOLOGICAL MEDICINE NOTES

- For prescription, fitting, and/or medical supervision of ocular prosthetic (artificial eye) adaptation by a physician, see evaluation and management services, including office and other outpatient services,…office or other outpatient consultations,…or general ophthalmological service codes… ◀

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NEW NOTES FOR SPECIAL OTORHINOLARYNGOLOGIC SERVICES

- Special otorhinolaryngologic services are those diagnostic and treatment services not including in an evaluation and management service, including office or other outpatient services,…or office or other outpatient consultations… ◀

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NEW SECTION, NOTES, CODES FOR BEHAVIOR MANAGEMENT SERVICES

- 96202: Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patient with a mental or physical health diagnosis, administered by a 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 primary procedure)

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NEW SECTION, NOTES, CODES FOR BEHAVIOR MANAGEMENT SERVICES

- Notes under 96202:
  - (Do not report 96202 for behavior management services to the patient and the parent(s)/guardian(s)/caregiver(s) during the same session.)
  - (Do not report 96202 for less than 31 minutes of service)
- Notes under 96203:
  - (Use 96203 in conjunction with 96202)
  - (Do not report 96202, 96203 in conjunction with 97151-97158, 0632T, 0373T)
  - For educational services (eg, prenatal, obesity, or diabetic instructions) rendered to patients in a group setting, use 99078)
  - (For counseling and/or risk factor reduction intervention provided by a physician or other qualified health care professional to patient(s) without symptoms or established disease, see 99401-99404, 99406-99409, 99411, 99412)

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NEW & REVISED CODES FOR REMOTE THERAPEUTIC MONITORING SERVICES

- Remote therapeutic monitoring services…represent the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response. These data may represent objective device-generated integrated data or subjective inputs reported by a patient. These data are reflective of therapeutic responses that provide a functionally integrative representation of patient status.

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NEW & REVISED CODES FOR REMOTE THERAPEUTIC MONITORING SERVICES

- 98975: Remote therapeutic monitoring (eg, 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
  - 98978: "…"; device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days.

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NEW NOTES ASSOCIATED WITH HOME HEALTH PROCEDURES/SERVICES

- These codes are used by non-physician health care professionals. Physicians should utilize the home or residence service codes 99341-99350 and utilize CPT codes other than 99500-99600 for any additional procedure/service provided to patient living in a home or residence.

The following codes are used to report services provided in a patient's home or residence (including assisted living facility, group home, custodial care facility, non-traditional private homes, or schools. ◀

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