Stony Brook Medicine

JANUARY 6, 2021

LIHIMA
2021 CPT/OPPS Updates

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SPEAKER

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Healthcare professional with 16 years of experience in the hospital setting. Has worked for community hospitals, academic medical centers, and quality improvement organizations. Currently the Associate Director for Staff Development for the HIM department at Stony Brook University Hospital where she provides coding education for inpatient and outpatient coding, as well as for CDI. Serves as the subject matter expert for revenue cycle software with IT. Currently pursing Master's Degree in Healthcare Administration at SUNY Stony Brook and current president of LIHIMA.

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AGENDA

- Summary of Changes
- E/M Changes
- Surgical Changes
- Radiology Updates
- Path/Lab Updates
- Medicine Updates
- Category III Updates
- Inpatient Only List
- COVID Updates

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SUMMARY OF CHANGES

	Added	Deleted	Revised
Evaluation and Management Services	2	1	17
Anesthesia	0	0	0
Surgery	11	11	28
Radiology Services	2	2	6
Pathology and Laboratory Procedures	43	1	9
Medicine Services and Procedures	18	9	4
Category II Codes	0	0	1
Category III Codes	45	23	1
PLA Codes	85	7	3
Grand Total	**206**	**54**	**69**

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SUMMARY OF CHANGES

- No Modifier changes for Calendar year 2021
- Care Management Services Code and Guideline Revisions
- Chronic Care Management Services new add-on code for additional time reporting clinical staff time spent on care management activities
- Transitional Care Management (TCM) Code Revisions
- Deleted specified diagnostic red cell survival study for differential organ/tissue kinetics

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Evaluation & Management

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EVALUATION AND MANAGEMENT

- Major Revisions to Office/Other Outpatient E/M Guidelines regarding time and medical decision making
  - Does not impact inpatient, ED, observation, consultation (etc.) E/M levels
  - Guidelines should be completely reviewed before selecting a code
- Code 99201 has been deleted
- Codes 99202-99215 have been revised
  - Eliminated history and examination as key component
  - Code is now based on Medical Decision Making (MDM) **OR** total time on the date of the encounter

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

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EVALUATION AND MANAGEMENT

Deleted code 99201

- ~~**99201** Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:~~
  - ~~A problem focused history;~~
  - ~~A problem focused examination;~~
  - ~~Straightforward medical decision making.~~
- ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~
- ~~Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.~~

➢ Because 99201 and 99202 both had straightforward MDM, 99201 was no longer needed with the guideline revisions

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EVALUATION AND MANAGEMENT

➢ **99202**: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **straightforward medical decision making**. When using time for code selection, **15-29 minutes of total time** is spent on the date of the encounter.

➢ **99203**: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **low level of medical decision making**. When using time for code selection, **30-44 minutes of total time** is spent on the date of the encounter.

➢ **99204**: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **moderate level of medical decision making**. When using time for code selection, **45-59 minutes of total time** is spent on the date of the encounter.

➢ **99205**: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **high level of medical decision making**. When using time for code selection, **60-74 minutes of total time** is spent on the date of the encounter. (For services 75 minutes or longer, see Prolonged Services 99XXX)

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EVALUATION AND MANAGEMENT

- **99211**: Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. –*The concept of MDM does not apply to 99211.*
- **99212**: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **straightforward medical decision making**. When using time for code selection, **10-19 minutes of total time** is spent on the date of the encounter.
- **99213**: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **low level of medical decision making**. When using time for code selection, **20-29 minutes of total time** is spent on the date of the encounter.
- **99214**: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **moderate level of medical decision making**. When using time for code selection, **30-39 minutes of total time** is spent on the date of the encounter.
- **99215**: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **high level of medical decision making**. When using time for code selection, **40-54 minutes of total time** is spent on the date of the encounter. (For services 55 minutes or longer, see Prolonged Services 99XXX)

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OFFICE AND OTHER OUTPATIENT NEW PATIENT
LESS THAN 15 MINUTES

- Does the deletion of code 99201 mean that services of less than 15 minutes can no longer be reported for new patient?
- No, E/M services for these patients would be reported based upon MDM instead of time.

CPT Assistant, September 2020 pg.14

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OFFICE/OTHER OUTPATIENT E/M REVISION
99202-99215

- MDM required elements have been revised for this code range:

2020	2021
Number of Diagnoses or Management Options	Number and Complexity of Problems Addressed at the Encounter
Amount and/or Complexity of Data to be Reviewed	Amount and/or Complexity of Data to be Reviewed and Analyzed
Risk of Complications and/or Morbidity or Mortality	Risk of Complications and/or Morbidity or Mortality of Patient Management

See **Table 2** on pages 16-17 in CPT book for detailed discussion on MDM levels

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MDM: NUMBER AND COMPLEXITY OF THE PROBLEMS THAT ARE ADDRESSED AT AN ENCOUNTER

- Multiple new or established conditions may be addressed at the same time and may affect medical decision making
- Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition
- Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, **and** their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.
- The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition

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MDM: RISK & MORBIDITY

- For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.
- Risk also includes MDM related to the need to initiate or forego further testing, treatment and/or hospitalization.
- Morbidity is a state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

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EVALUATION AND MANAGEMENT: TIME

- For coding purposes, time for these services is the total time on the date of the encounter.
- It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter

https://www.mindtools.com//media/Resized-Images/Articles/Time_Management/19_IS_17606878_robas_1x1.jpg

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EVALUATION AND MANAGEMENT: TIME

- Activities Included in total time:
  - Preparing to see the patient (eg, review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, tests, or procedures
  - Referring and communicating with other health care professionals (when not separately reported)
  - Documenting clinical information in the electronic or other health record
  - Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)

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EVALUATION AND MANAGEMENT: TIME

- Time ranges are exact: The minimum time in the time range must be met for the visit to be leveled by time.
- Providers may not include staff time when documenting their total time.
- Time will no longer need to be dominated by counseling.
- All time used for leveling the E/M must be on the same day of the face-to-face visit.

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IS A HISTORY AND/OR EXAMINATION NECESSARY?

- The nature and extent of the history and/or physical examination is determined by the treating physician or other qualified health care professional reporting the service.
- The care team may collect information and the patient or caregiver may supply information directly (eg, by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional.
- The extent of history and physical examination is not an element in selection of office or other outpatient services.
  - Office or other outpatient services include a medically appropriate history and/or physical examination, when performed.

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PROLONGED SERVICES

New Codes for Prolonged Services

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

▶(Use 99417 in conjunction with 99205, 99215)◀

▶(Do not report 99417 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416)◀

▶(Do not report 99417 for any time unit less than 15 minutes)◀

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PROLONGED SERVICES

New Codes for Prolonged Services

- **+G2212** (to be used in place of CPT code 99417 for Medicare) Prolonged office or other outpatient E/M service(s) beyond the **maximum** required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient E/M)

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INCREASED COMPLEXITY

- **+G2211**: Visit complexity inherent to E/M associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single serious, or complex chronic condition. (Add-on code, list separately in addition to office/outpatient E/M visit, new or established.)
- *On Dec. 21, Congress delayed implementation of the primary care add-on code, G2211, for three years as part of the 2020 Year End Funding Bill and COVID-19 Emergency Funding, and it applied the savings to increase Medicare base payments for all services and specialties by an additional 3.75%. All other anticipated payment, coding, and documentation changes for 2021 are expected to go into effect as planned.*

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Surgery Codes Update

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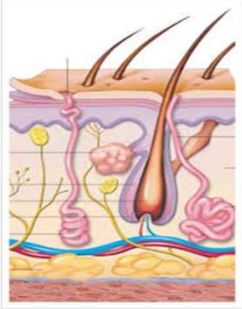
Integumentary System



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Breast Repair and/or Reconstruction Highlights

- New introductory guidelines (starts on pg. 123 of code book)
- New, revised and updated parenthetical notes throughout the subsection to reflect the changes
- These changes are specific to update and reflect current procedures/practice and to clarify provider overlap in the code descriptions.
- Guidelines specify that reconstruction of bilateral breasts may occur in the same session, using different techniques or a combination of techniques.

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INTEGUMENTARY SYSTEM

- **15 Code revissions:** 19318, 19325, 19328, 19330, 19340, 19342, 19357, 19361, 19364, 19367- 19371 and 19380
  - Conversion of code 19325 (Breast augmentation with implant) to a parent code
  - Revision of code 19340 and 19342 (clarified terms immediate and delayed)
  - Conversion of codes 19367 and 19369 (TRAM flap) to child codes
  - Removal of ruptured breast implant (19330)
  - Revision of codes for Peri-Implant capsule and capsulectomy (19370, 19371)
  - Autologous Reconstruction (19380)
- Codes 11970 and 11971 have been updated in the Introduction section by removing the term “prosthesis” and adding “implant”

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INTEGUMENTARY SYSTEM

- **11970** Replacement of tissue expander with permanent *Implant* (“prosthesis” has been revised to “implant”)
- **11971** Removal of tissue expander*(s)* without insertion of *Implant* (the pleural for expander has been removed; “prosthesis” has been revised to “implant”)
- **19318** *Breast* Reduction (“Mammaplasty” revised to Breast)
- **19325** *Breast augmentation with implant* (“Mammaplasty, augmentation with prosthetic implant” has been revised to Breast…..)
- **19328** Removal of intact *breast* implant (“Mammary” revised to Breast)
- **19330** Removal of ruptured *breast* implant, *including implant contents (e.g. Saline, silicone gel)* (“Mammary” revised to ruptured breast; “material” revised to Including….)
- **19340** Insertion of Breast *implant on same day of mastectomy* (i.e.. Immediate) (“prosthesis” revised to Breast; “ following mastopexy, mastectomy or reconstruction”, revised to “on same day….”
- **19342** *Insertion or replacement* of breast *implant on separate day from mastectomy* (“delayed” removed, “or replacement” added, “prosthesis” revised to Implant; “following mastopexy or in reconstruction” revised to On Separate Day….)
- **19357** *Tissue expander placement in breast reconstruction, including subsequent expansion (s)* (“Breast reconstruction, immediate or delayed with tissue expander” revised to….)

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INTEGUMENTARY SYSTEM

- **19361** Breast reconstruction with latissimus dorsi flap (“without prosthetic implant” removed)
- **19364** -with free flap *(e.g. TRAM, DIEP, SIEA, GAP flap)* (“breast reconstruction” removed)
- **19367** -with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap (“Breast reconstruction including closure of donor site” removed)
- **19368** -with *single-pedicled transverse rectus abdominus myocutaneous (TRAM) flap, requiring separate* microvascular anastomosis (supercharging) (“single-pedicled…..” added)
- **19369** -with *bipedicled transverse rectus abdominus myocutaneous (TRAM) flap* (“breast reconstruction w/TRAM flap double pedicle including donor site” revised..)
- **19370** *Revision of peri-implant capsule, breast, including* capsulotomy, *capsulorrhaphy, and/or partial capsulectomy.* (“open prosthetic” revised to Revision….)
- **19371** Peri-*implant* capsulectomy, breast *complete, including removal of intracapsular contents* (“prosthetic” revised to Implant, “complete…..”, added)
- **19380** Revision of reconstructed breast *(e.g. Significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)* (eg….added)

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INTEGUMENTARY SYSTEM

Repair and/or Reconstruction Delete

- ~~**19324** Mammaplasty, augmentation; without prosthetic implant~~

▸(19324 has been deleted. To report breast augmentation with fat grafting see 15771, 15772)◂

- ~~**19366** Breast reconstruction with other technique~~

▸(19366 has been deleted.)◂

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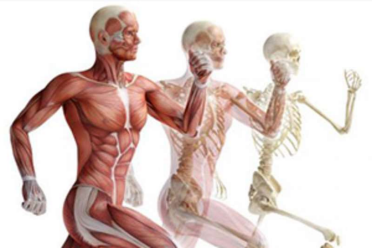
Musculoskeletal System



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MUSCULOSKELETAL SYSTEM

- Arthroscopic Removal of Foreign Bodies (new guideline note on pg. 205 of CPT book)
  - Arthroscopic removal of loose body(ies) or foreign body(ies) (i.e. 29819, 29834, 29861, 29894, 29904) may be reported only when the loose body(ies) or foreign body(ies) is equal to or larger than the diameter of the arthroscopic cannula(s) used for the specific procedure and can only be removed through a cannula larger than that used for the specific procedure or through a separate incision or through a portal that has been enlarged to allow removal of the loose or forgein body(ies).

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MUSCULOSKELETAL SYSTEM

- Arthroscopic Removal of Foreign Bodies
  - This new guideline clarifies the use of arthroscopic removal of loose body(ies) or foreign body(ies) and refers to reporting the appropriate codes when the loose body(ies) or foreign body(ies) is/are equal to or larger than the diameter of the arthroscopic cannula(s) used for the specific procedure.
  - Prior to the addition of this guideline the CPT code set did not define a threshold of loose-body size for the applicable arthroscopic procedure codes.

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MUSCULOSKELETAL SYSTEM

- **29822** debridement, limited, *1 or 2 discrete structures (e.g. humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial space, foreign body [ies])* ("1 or 2 discrete….." added)
- **29823** debridement, extensive, *3 or more discrete structures (e.g. humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial space, foreign body [ies])*("3 or more…." added)

See CPT Assistant December 2020 page 8

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Respiratory System

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Nose Repair Add

- **30465** Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction

‣(30465 excludes obtaining graft. For graft procedures, see 15769, 20900, 20902, 20910, 20912, 20920, 20922, 20924, 21210, 21235)◂

‣(Do not report 30465 in conjunction with 30468, when performed on the ipsilateral side)◂

‣(For repair of nasal vestibular lateral wall collapse with subcutaneous/submucosal lateral wall implant(s) use 30468)◂

- ● **30468** Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)

‣(30468 is used to report a bilateral procedure. For unilateral procedure, use modifier 52)◂

‣(Do not report 30468 in conjunction with 30465, when performed on the ipsilateral side)◂

‣(For repair of nasal vestibular stenosis [eg, spreader grafting, lateral nasal wall reconstruction use 30465)◂

‣(For repair of nasal vestibular stenosis or collapse without cartilage graft, lateral wall reconstruction, or subcutaneous/submucosal implant [eg, radiofrequency remodeling, lateral wall suspension, or stenting without graft or subcutaneous/ submucosal implant], use 30999)◂

  - Status J1

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Stony Brook Medicine RESPIRATORY SYSTEM

Nose Repair Add

- Code 30468 differs from the procedure identified by 30465 because code 30465 involves a larger incision(s), lateral nasal wall reconstruction, and possible graft harvest performed in a non-office setting.
- A different code was needed to identify opening the collapsed passage using minimally invasive techniques and absorbable lateral wall implants that would involve less physician work to perform.

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Stony Brook Medicine RESPIRATORY SYSTEM

Lungs and Pleura Deleted

- ~~**32405** Biopsy, lung or mediastinum, percutaneous needle~~

‣(32405 has been deleted. To report percutaneous core needle biopsy of lung or mediastinum, use 32408) ◂

Lungs and Pleura Add

- ● **32408** Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance when performed

‣(Do not report 32408 in conjunction with 76942, 77002, 77112, 77021) ◂

‣(For fine needle aspiration biopsy, see 10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012, 10021)◂

  - Status J1

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Stony Brook Medicine RESPIRATORY SYSTEM

Lungs and Pleura Add

- Prior to 2021 code 32405 did not include image guidance as part of the procedure. Given that the vast majority of these procedures include image guidance, all types of imaging guidance have been included in code 32408.
- Code 32408 is only reported once per lesion sampled in a single session.
- When FNA and core needle biopsy of the lung or mediastinum are performed on the same lesion at the same session on the same day using the same type of imaging guidance modifier 52 should be used with either the FNA or core needle biopsy code.

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- Use Modifier 59 when:
  - More than one core needle biopsy of the lung or mediastinum with image guidance is performed on separate lesions at the same session on the same day, use 32408 once for each lesion.
  - A core needle biopsy of the lung or mediastinum with imaging guidance is performed at the same session as a core biopsy of a site other than the lunch or mediastinum (eg, liver) bother the core needle biopsy for the other site and the imaging guidance for that additional core needle biopsy may be reported separately.

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- Use Modifier 59 when:
  - FNA biopsy and core needle biopsy of the lung or mediastinum are performed on the same lesion at the same session on the same day using different types of imaging guidance, both image guided biopsy codes may be reported separately.
  - FNA biopsy is performed on one lesion and core needle biopsy of the lung or mediastinum I sperformed on a separate lesion at the same session on the same day using different types of imaging guidance, both the modality-specific image-guided FNA biopsy code and 32408 may be reported separately.

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Cardiovascular System

https://media.istockphoto.com/photos/heart-attack-and-heart-disease-picture-id1210336572?k=6&m=1210336572&s=612x612&w=0&h=ILvhmfVLBsiTiq1b_Q-sIRqB-_Bu1WiiqtogFzfkqOM=

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HEART & PERICARDIUM/SHUNTING PROCEDURE ADDITIONS

- ● **33741** Transcatheter atrial septostomy (TAS) for congenital cardiac anomalies to create effective atrial flow, including all imaging guidance by the proceduralist, when performed, any method(eg, Rashkind, Sang-Park, balloon, cutting balloon, blade)

‣(Do not report modifier 63 in conjunction with 33741)◂

‣(For transseptal puncture, use 93462)◂

- ● **33745** Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles);initial intracardiac shunt
- **+**● **33746** -each additional intracardiac shunt location (List separately in addition to code for primary procedure)

‣(Use 33746 in conjunction with 33745) ◂

‣(Do not report 33745, 33746 in conjunction with 93530, 93531, 93532, 92533) ◂

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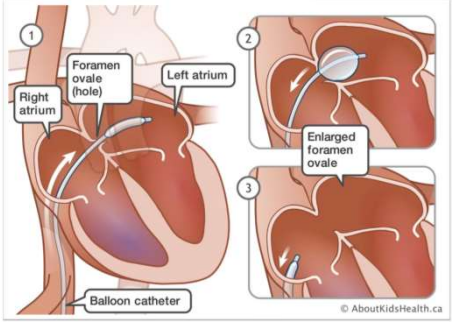
HEART & PERICARDIUM/SHUNTING PROCEDURE ADDITIONS



https://assets.aboutkidshealth.ca/akhassets/IMD_TGA_balloon_septostomy_EN.jpg?RenditionID=19

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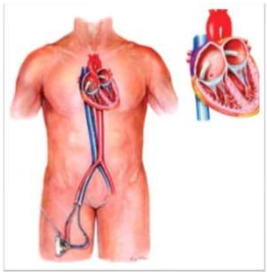
HEART AND PERICARDIUM/CARDIAC ASSIST ADDITIONS

- #●**33995** Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only
- #●**33997** Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion

(For removal of left or right heart ventricular assist device via open approach, see appropriate vessel repair code (eg, 35206, 35226, 35286, 35371)



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CARDIOVASCULAR CODE REVISIONS

- **33990** *left heart*, atrial access only ("left heart" added)
- **33991** *left heart*, both arterial and venous access, with transseptal puncture ("left heart" added)
- **33992** Removal of percutaneous *left heart ventricular assist device, arterial or arterial and venous cannula(s),* at separate and distinct session from insertion. ("left heart", "arterial or arterial and venous cannula(s)" added)
- **33993** Repositioning of percutaneous *right or left heart* ventricular assist device with imaging guidance at separate distinct session from insertion ("right or left heart" added)

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Male/Female Genital Systems

https://www.google.com/url?sa=i&url=https%3A%2F%2Fwww.zoonar.com%2Fphoto%2Fmale-female-and-transgender-gender-symbols-laser-neon_2656437.html&psig=AOvVaw2eeSc7HPstDM1IPcEuAcfs&ust=1609734422692000&source=images&cd=vfe&ved=0CAIQjRxqFwoTCI99bu_VgO4CFQAAAAAdAAAAABAF

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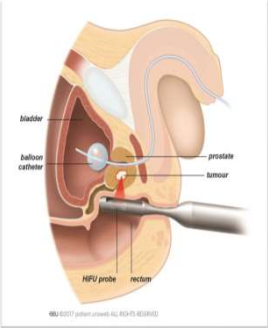
MALE GENITAL SYSTEM

Male Genital/Prostate/Other Procedures Add

- ● **55880** Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance.
  - This used to be assigned to an unlisted procedure code and now has its own specific code with a J1 status.



https://prostatematters.co.uk/wp-content/uploads/2018/11/hifu-diagram.jpg

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FEMALE GENITAL SYSTEM

Female Genital System/Cervix Uteri/Endoscopy Add

- +● **57465** Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhitening effect (List separately in addition to code for primary procedure)

▸(Use 57465 in conjunction with 57420, 57421, 57452, 57454, 57455, 57456, 57460, 57461) ◂

  - Status N
  - The computer-aided device used during colposcopy described in this code includes optical dynamic spectral imaging that helps with mapping of any abnormal areas for localizing biopsy sites within the cervix. The intended use of the computer-aided colposcopy is to aid in the biopsy of the cervix.

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Stony Brook Medicine

FEMALE GENITAL SYSTEM

Female Genital System/Vagina/Incision Delete

- ~~**57112** with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)~~

▸(57112 has been deleted)◂

Female Genital System/Corpus Uteri/Excision Delete

- ~~**58293** with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control~~

▸(58293 has been deleted)◂

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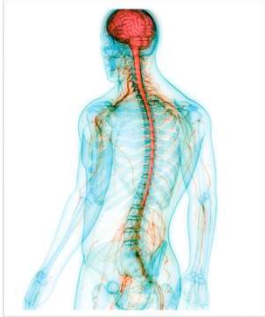
Stony Brook Medicine

Nervous System



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

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Stony Brook Medicine

Skull, Meninges, and Brain/Neurostimulators (Intracranial) Delete

- ~~**61870** Craniectomy for implantation of neurostimulator electrodes, cerebellar, cortical~~

(61870 has been deleted)

Skull, Meninges, and Brain/Neuroendoscopy Delete

- ~~**62163** Neuroendoscopy,~~ intracranial; with retrieval of foreign body

(62163 has been deleted)

Spine and Spinal Cord/Incision Delete

- ~~**63180** Laminectomy and section of dentate ligaments, with or without dural graft, cervical; 1 or 2 segments~~
- ~~**63182** Laminectomy and section of dentate ligaments, with or without dural graft, cervical; more than 2 segments~~

(63180, 63182 have been deleted)

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Stony Brook Medicine

- **64455** *plantar common digital nerve(s) (e.g. Morton's neuroma)* (text added)
- **64479** *transforaminal epidural, with imaging guidance (fluoroscopy or CT)*, cervical or thoracic, single level ("transforaminal…." added)
- **64480** *transforaminal epidural, with imaging guidance (fluoroscopy or CT)*, cervical or thoracic, each additional level (List separately in addition to code for primary procedure) ("transforaminal…." added)
- **64483** *transforaminal epidural, with imaging guidance (fluoroscopy or CT)*, lumbar or sacral, single level ("transforaminal…." added)
- **64484** *transforaminal epidural, with imaging guidance (fluoroscopy or CT)*, lumbar or sacral, each additional level (List separately in addition to code for primary procedure) ("transforaminal….." added)

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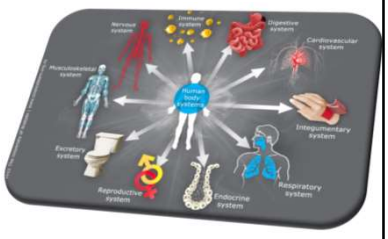
Stony Brook Medicine

Other Body Systems



https://static.sciencelearn.org.nz/images/images/000/002/307/embed/The-body-s-systems20161104-16595-1aca5q9.jpg?1522307588

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Stony Brook Medicine DIGESTIVE SYSTEM

Abdominal, Peritoneum, and Omentum Excision, Destruction Delete

- ~~**49220** Staging laparotomy for Hodgkins disease or lymphoma (includes splenectomy, needle or open biopsies of both liver lobes, possibly also removal of abdominalnodes, abdominal node and/or bone marrow biopsies, ovarian repositioning)~~

(49220 has been deleted)

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Stony Brook Medicine AUDITORY SYSTEM

Middle Ear/Repair Delete

- ~~**69605** Revision mastoidectomy; with apicectomy~~

(69605 has been deleted)

Middle Ear/Other Procedures Adds

- **69705** Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral
- **69706** Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral

(Do not report 69705, 69706 in conjunction with 31231, 92511)

  - Prior to 2021 these codes went to an unlisted procedure, now they are both J1 status

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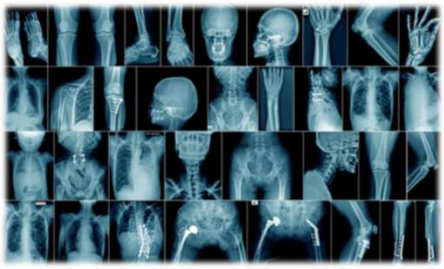
Stony Brook Medicine

Radiology Updates



https://skeletalrad.org/sites/default/files/skeleton-bg.jpg

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Stony Brook Medicine

LUNG CANCER SCREENING CT

- **71271** Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)

(Do not report 71271 in conjunction with 71250, 71260, 71270)

(Do not report 71271 for breast CT procedures)

(For cardiac computed tomography of the heart, see 75571, 75572, 75573, 75574)

- Previously lung cancer screening was conducted using standard chest x-ray.

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Stony Brook Medicine

MEDICAL PHYSICS DOSE EVALUATION

- **76145** Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report
- Currently, two other codes describe the work performed by medical radiation physicists in radiation oncology (77370, 77336)
- New code 76145 was added to describe dose calculation after a diagnostic or therapeutic endovascular procedure such as:
  - Interventional Radiology: TIPS, venous interventions, embolization
  - Cardiology: Electrophysiology, Cardiac revascularization
  - Endovascular Neurosurgery: Embolization, thrombectomy

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Stony Brook Medicine

DELETED RADIOLOGY CODES

Diagnostic Ultrasound/Other Procedures Delete

- ~~**76970** Ultrasound study follow-up (specify)~~

(76970 has been deleted)

- CPT explanation of rationale for removal of 76970 –CMS identified exponential use of the code. After review and examination CMS determined the code was being inappropriately reported for follow-up ultrasound performed for varicose vein procedures and was therefore recommended for deletion

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Stony Brook Medicine

RADIOLOGY CODE REVISIONS

- **71250** Computed tomography, thorax, *diagnostic*, without contrast material ("diagnostic" added)
- **71260**…with contrast material ("diagnostic" added to the description)
- **71270** without contrast material(s) ("diagnostic" added to the description)
- **74425** Urography antegrade, radiological supervision and interpretation ("pyelostogram, nephrostogram, loopogram" removed)
- **76513** anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, *unilateral or bilateral* ("unilateral or bilateral" added)
- **78130** Red cell survival study;

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Pathology and Laboratory

https://www.chla.org/sites/default/files/thumbnails/image/shutterstock_427035307%282%29.jpg

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Stony Brook Medicine

PATHOLOGY AND LABORATORY

Summary

- 128 New Codes (majority for PLA)
- 11 Revised Codes
- 8 Deleted Codes
- COVID Related Codes to be discussed later on

https://www.ama-assn.org/practice-management/cpt/cpt-pla-codes

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Stony Brook Medicine

Medicine Updates

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Stony Brook Medicine

MEDICINE UPDATES

- Summary
  - Various code and guideline revisions to accommodate Office and Other Outpatient changes
  - New code for immune globulin
  - Ophthalmology Code and Guideline Revisions
  - Expansion of vestibular evoked myogenic potential testing and auditory evoked potential testing procedure codes
  - New codes for Electrocardiographic recording
  - New code for Exercise test
  - Atrial Septostomy Deletes

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Category III Codes

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SUMMARY

- Summary
  - Four new Category III codes (0609T-0612T) have been established to report magnetic resonance (MR) spectroscopy and determination and localization of discogenic pain (cervical, thoracic, or lumbar)
  - A parenthetical note has been added to exclude reporting of these new codes (0609T-0612T) with other MR imaging of the spinal canal codes. These codes were established because the existing MRS CPT code 76390 is reported for general MR spectroscopy in any part of the body (eg, brain, prostate, breast) and is not defined to any particular anatomy
  - The current Category III code is specifically for MRS of the vertebral discs, performed with this specific analysis
  - Cone-beam CT of the breast is performed on a dedicated machine designed specifically for this purpose
  - Six Category III codes (0633T-0638T) have been added to report CT of the breast
  - Parenthetical notes following codes 76376 and 76377 have been revised to include the new Category III codes because 3D is included in the new codes.

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Stony Brook Medicine

DELETED

Code	Description	Replaced
0058T	Cryopreservation ovary tiss	89398
0085T	Breath test heart reject	84999
0111T	Rbc membranes fatty acids	84999
0126T	Chd risk imt study	93998
0228T	Njx tfrml eprl w/us cer/thor	64999
0229T	Njx tfrml eprl w/us cer/thor	64999
0230T	Njx tfrml eprl w/us lumb/sac	64999
0231T	Njx tfrml eprl w/us lumb/sac	64999
0295T	Ext ecg complete	93241-93248
0296T	Ext ecg recording	93241-93248
0297T	Ext ecg scan w/report	93241-93248
0298T	Ext ecg review and interp	93241-93248

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Stony Brook Medicine

DELETED

Code	Description	Replaced
0381T	Ext h rate epi sz 14 days	95999
0382T	Ext h rate sz 14 day ri only	95999
0383T	Ext h rate sz 15-30 days	95999
0384T	Ex h rate sz 15-30 day ri	95999
0385T	Ex h rate for sz ovr 30 day	95999
0386T	Ex h rate sz 30+ day ri only	95999
0396T	Intraop kinetic balnce sensr	27599
0400T	Mltispectrl digital les alys	96999
0401T	Mltispectrl digital les alys	96999
0405T	Ovrsght xtrcorp liv asst pat	99499
0595T	Rem of hum ext cont intramed length dev	Rescinded March 2020

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Stony Brook Medicine

NEW CODES

Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate
0594T	Osteotomy, humerus, with insertion of externally controlled intramedullary lengthening device (includes intraop imaging)	J1	5114	75.6664	$6,264.95
0596T	Temp female intraurethral vlv-pmp (voiding prosthesis) 1st insertion	T	5372	6.9419	$574.77
0597T	Temp fml iu valve-pmp rplcmt	T	5372	6.9419	$574.77
0598T	Noncontact real time fluor wnd img 1st	T	5722	3.1939	$264.45
0599T	Ncntc r-t fluor wnd img each additional site	N			
0600T	Ablation, irreversible electroportaion 1 or more tumors per organ percutaneous (including image guidance)	J1	5362	107.5843	$8,907.66
0601T	Ablation, irreversible electroportaion 1 or more tumors per organ open (including fluroscopic and ultrasound guidance)	J1	5362	107.5843	$8,907.66
0602T	Transdermal gfr measurements	Q4			
0603T	Transdermal gfr monitoring	Q4			

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Stony Brook Medicine

NEW CODES

Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate
0594T	Osteotomy, humerus, with insertion of externally controlled intramedullary lenghting device (includes intraop imaging)	J1	5114	75.6664	$6,264.95
0596T	Temp female intraurethral vlv-pmp (voiding prosthesis) 1st insertion	T	5372	6.9419	$574.77
0597T	Temp fml iu valve-pmp rplcmt	T	5372	6.9419	$574.77
0600T	Ablation, irreversible electroportaion 1 or more tumors per organ percutaneous (including image guidance)	J1	5362	107.5843	$8,907.66
0601T	Ablation, irreversible electroportaion 1 or more tumors per organ open (including fluroscopic and ultrasound guidance)	J1	5362	107.5843	$8,907.66
0613T	Perc trans cath implant of intra-arterial septal shunt device (includes r/l heart cath, echo, and image guidance)	E1			
0614T	Rmvl&rplcmt substernal impl dfb gen	J1	5231	278.2729	$23,040.16
0616T	Insertion of iris prosthesis	J1	5491	25.1115	$2,079.16
0617T	Inser iris prosth w/rmvl of crystalline lens &ins of IOL	J1	5492	47.3174	$3,917.74

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Stony Brook Medicine

NEW CODES

Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate
0618T	Ins iris prosth sec io lens placement or exchange	J1	5492	47.3174	$3,917.74
0619T	Cysto w/prst8 commissurotomy	J1	5375	53.3099	$4,413.90
0620T	Evasc ven artlz tibl/prnl vn	J1	5194	194.0167	$16,064.00
0621T	Trabeculostomy interno laser	E1			
0622T	Trabeculostomy int lsr w/scp	E1			
0627T	Perc injection allogenic cellular and/or tissue based product, intervertbebral disc, uni or bilateral fluor lmbr 1st	J1	5115	148.7344	$12,314.76
0628T	Perq njx algc fluor lmbr ea	N			
0629T	Perc injection allogenic cellular and/or tissue based product, intervertbebral disc, uni or bilateral ct lmbr 1st	J1	5115	148.7344	$12,314.76
0630T	Perq njx algc ct lmbr ea	N			
0632T	Perc us ablt nrv pulm art	E1			

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Stony Brook Medicine

Inpatient Only List

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Stony Brook Medicine

INPATIENT ONLY LIST

- In this rule, we are finalizing our proposal to **eliminate** the Inpatient Only (IPO) list over a **three-year transitional period**, beginning with the removal of approximately 300 primarily musculoskeletal-related services, with the list completely phased out by CY 2024.

https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

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INPATIENT ONLY LIST

- This will make these procedures eligible to be paid by Medicare in the hospital outpatient setting when outpatient care is appropriate, as well as maintain our ability to pay for these services in the hospital inpatient setting when inpatient care is appropriate, as determined by the physician.
- Additionally, procedures removed from the IPO list ***may*** become subject to medical review activities related to the 2-midnight rule.

https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

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Stony Brook Medicine

INPATIENT ONLY LIST

- In this rule, we are finalizing a policy in which procedures removed from the IPO list beginning January 1, 2021 will be indefinitely exempted from site-of-service claim denials under Medicare Part A, eligibility for Beneficiary and Family-Centered Care-Quality Improvement Organization (BFCC-QIO) referrals to Recovery Audit Contractors (RACs) for noncompliance with the 2-midnight rule, and RAC reviews for “patient status” (that is, site-of-service)

https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

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INPATIENT ONLY LIST

- This exemption will last until we have Medicare claims data indicating that the procedure is more commonly performed in the outpatient setting than the inpatient setting.
- This exemption will allow providers more time to become accustomed to the new ability to bill for Medicare payment of claims for services that were previously only paid on an inpatient basis.

https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

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Stony Brook Medicine

INPATIENT ONLY LIST

- Removal of Musculoskeletal Procedures Such As:
  - Anesthesia related to orthopedic procedures
  - Spinal fusions
  - Amputations
  - Replantations
  - Lefort Procedures
  - Reconstructive Surgery
  - Scoliosis Treatment
  - Joint Replacements
- Most procedures assigned to a J1 status
- For a complete listing please see the CMS website here.

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INPATIENT ONLY LIST

Non-Musculoskeletal Procedures Removed from Inpatient Only List

CY 2021 CPT Code	CY 2021 Short Descriptor	CY 2021 Long Descriptor	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
35372	Rechanneling of artery	Thromboendarterectomy, including patch graft, if performed; deep (profunda) femoral	J1	5184
35800	Explore neck vessels	Exploration for postoperative hemorrhage, thrombosis or infection; neck	J1	5184
37182	Insert hepatic shunt (tips)	Insertion of transvenous intrahepatic portosystemic shunt(s) (tips) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)	J1	5193
37617	Ligation of abdomen artery	Ligation, major artery (eg, post-traumatic, rupture); abdomen	J1	5183
38562	Removal pelvic lymph nodes	Limited lymphadenectomy for staging (separate procedure); pelvic and para-aortic	J1	5362
43840	Repair of stomach lesion	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	J1	5331

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INPATIENT ONLY LIST

Non-Musculoskeletal Procedures Removed from Inpatient Only List

CY 2021 CPT Code	CY 2021 Short Descriptor	CY 2021 Long Descriptor	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
44300	Open bowel to skin	Placement, enterostomy or cecostomy, tube open (eg, for feeding or decompression) (separate procedure)	J1	5302
44314	Revision of ileostomy	Revision of ileostomy; complicated (reconstruction in-depth) (separate procedure)	T	5055
44345	Revision of colostomy	Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)	J1	5341
44346	Revision of colostomy	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)	J1	5341
44602	Suture small intestine	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation	J1	5303

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INPATIENT ONLY LIST

Non-Musculoskeletal Procedures Removed from Inpatient Only List

CY 2021 CPT Code	CY 2021 Short Descriptor	CY 2021 Long Descriptor	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
49010	Exploration behind abdomen	Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)	J1	5341
49255	Removal of omentum	Omentectomy, epiploectomy, resection of omentum (separate procedure)	J1	5341
51840	Attach bladder/urethra	Anterior vesicourethropexy, or urethropexy (eg, marshall-marchetti-krantz, burch); simple	J1	5415
56630	Extensive vulva surgery	Vulvectomy, radical, partial;	J1	5415
61624	Transcath occlusion cns	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)	J1	5194

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COVID Updates

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LAB CODES

Code	Description	Effective Date
87635	SARS-COV-2 COVID-19 AMP PRB (DNA/RNA)	3/13/2020
86328	Immunoassay NFCT AB SARSCOV2 COVID19 (single step)	4/10/2020
86769	SARS-COV-2-COVID-19 ANTIBODY	4/10/2020
87426	CORONAVIRUS AG 1A (multistep method)	6/25/2020
86408	NEUTRLZG ANTB SARSCOV2 SCR	8/10/2020
86409	NEUTRLZG ANTB SARSCOV2 TITER	8/10/2020
86413	SARS-COV-2 ANTB QUANTITATIVE	9/8/2020
0202U	NFCT DS 22 TRGT SARS-COV-2 (Biofire Respiratory Panel)	5/20/2020
0223U	NFCT DS 22 TRGT SARS-COV-2 (QIAstat-Dx Respiratory Panel)	6/25/2020
0224U	ANTIBODY SARS-COV-2 TITER(S) (Mt. Sinai)	6/5/2020
0225U	NFCT DS DNA&RNA 21 SARSCOV2 (ePlex Respiratory Panel)	8/10/2020
0226U	SVNT SARSCOV2 ELISA PLSM SRM (Tru-Immune)	8/10/2020

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DIAGNOSTIC COVID TEST VS ANTIBODY COVID TEST

- Antibody testing determines whether you had COVID-19 in the past and now have antibodies against the virus.
- A test to diagnose COVID-19 determines if you currently have the disease.

https://www.fda.gov/files/Coronavirus-testing-basics-CU-main-image-1600x900.png

https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/covid-antibody-tests/faq-20484429

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DIAGNOSTIC COVID TEST VS ANTIBODY COVID TEST

- Antibody Test
  - Also known as serology testing, is usually done after full recovery from COVID-19.
  - It indicates that you were likely infected with COVID-19 at some time in the past.
  - It may also mean that you have *some* immunity.
  - There's a lack of evidence on whether having antibodies means you're protected against reinfection with COVID-19.
  - The timing and type of antibody test affects accuracy. If you have testing too early in the course of infection, when the immune response is still building up in your body, the test may not detect antibodies. So antibody testing is not recommended until at least 14 days after the onset of symptoms.

https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/covid-antibody-tests/faq-20484429

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DIAGNOSTIC COVID TEST VS ANTIBODY COVID TEST

- Diagnostic Test
  - **PCR Test:** Also called a molecular test, this COVID-19 test detects genetic material of the virus using a lab technique called polymerase chain reaction (PCR).
    - PCR tests are very accurate when properly performed by a health care professional, but the rapid test can miss some cases.
  - **Antigen Test:** This COVID-19 test detects certain proteins in the virus.
    - A positive antigen test result is considered accurate when instructions are carefully followed, but there's an increased chance of false-negative results — meaning it's possible to be infected with the virus but have a negative result. Depending on the situation, the doctor may recommend a PCR test to confirm a negative antigen test result.

https://www.mayoclinic.org/diseases-conditions/coronavirus/expert-answers/covid-antibody-tests/faq-20484429

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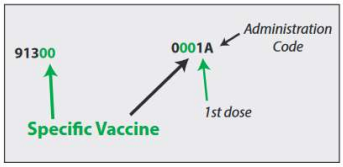
CPT/HCPCS VACCINATION CODES

Figure 1. Relationship Between Vaccine Product and Administration Code(s)



- Do not report 90460-90474 for the administration of SARS-CoV-2 (Coronavirus disease [COVID-19]) vaccines.

https://www.ama-assn.org/system/files/2020-11/cpt-assistant-guide-covid-vaccine-coding-2020.pdf

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Stony Brook Medicine

CPT/HCPCS VACCINATION CODES

(Pfizer- FDA EUA Approval 12/11/20)

- **91300:** Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, **30 mcg/0.3mLdosage**, diluent reconstituted, for intramuscular use.
  - **0001A** Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, **30 mcg/0.3mL dosage**, diluent reconstituted; **first dose**
  - **0002A** Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, **30 mcg/0.3mL dosage**, diluent reconstituted; **second dose**

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CPT/HCPCS VACCINATION CODES

(Moderna FDA EUA Approval 12/18/20)

- **91301:** Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, **100 mcg/0.5mL dosage**, for intramuscular use.
  - **0011A** Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, **100 mcg/0.5mL** dosage; **first dose**
  - **0012A** Immunization administration by intramuscular injection of Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, **100 mcg/0.5mL** dosage; **second dose**

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Stony Brook Medicine

CPT/HCPCS VACCINATION CODES

AstraZeneca (no date yet)

- **91302:** Severe acute respiratory syndrome coronavirus2 (SARS-CoV-2) (coronavirusdisease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010viral particles/0.5mL dosage, for intramuscular use
  - **0021A** Immunization administration by intramuscular injection Severe acute respiratory syndrome coronavirus2 (SARS-CoV-2) (coronavirusdisease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010viral particles/0.5mL dosage; **first dose**
  - **0022A** Immunization administration by intramuscular injection Severe acute respiratory syndrome coronavirus2 (SARS-CoV-2) (coronavirusdisease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010viral particles/0.5mL dosage; **Second Dose**

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NEW ICD-10-CM CODES EFFECTIVE 1/1/21

- **J12.82**, Pneumonia due to COVID-19 ***J12.82 will replace current code J12.89 Other viral pneumonia as of 1/1/21***
- **M35.81**, Multisystem inflammatory syndrome ***M35.81 will replace current code M35.8 as of 1/1/21***
- **Z20.822**, Contact with and (suspected) exposure to COVID-19 ***Z20.822 will replace current code Z20.828 as of 1/1/21***
- **Z86.16**, Personal history of COVID-19 ***Z86.16 will replace current code Z86.19 as of 1/1/21***
- **M35.89**, Other specified systemic involvement of connective tissue
- **Z11.52**, Encounter for screening for COVID-19 **Z11.52 will replace current code Z11.59 as of 1/1/21***

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Stony Brook Medicine

NEW ICD-10-PCS CODES EFFECTIVE 1/1/21

Vaccines

- **XW013S6** Introduction of COVID-19 Vaccine Dose 1 into **Subcutaneous Tissue**, Percutaneous Approach, New Technology Group 6
- **XW013T6** Introduction of COVID-19 Vaccine Dose 2 into **Subcutaneous Tissue**, Percutaneous Approach, New Technology Group 6
- **XW013U6** Introduction of COVID-19 Vaccine into **Subcutaneous Tissue**, Percutaneous Approach, New Technology Group 6
- **XW023S6** Introduction of COVID-19 Vaccine Dose 1 into **Muscle**, Percutaneous Approach, New Technology Group 6
- **XW023T6** Introduction of COVID-19 Vaccine Dose 2 into **Muscle**, Percutaneous Approach, New Technology Group 6
- **XW023U6** Introduction of COVID-19 Vaccine into **Muscle**, Percutaneous Approach, New Technology Group 6

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NEW ICD-10-PCS CODES EFFECTIVE 1/1/21

Monoclonal Antibody

- **XW013K6** Introduction of **Leronlimab** Monoclonal Antibody into Subcutaneous Tissue, Percutaneous Approach, New Technology Group 6
- **XW043E6** Introduction of **Etesevimab** Monoclonal Antibody into **Central Vein**, Percutaneous Approach, New Technology Group 6
- **XW033E6** Introduction of **Etesevimab** Monoclonal Antibody into **Peripheral Vein**, Percutaneous Approach, New Technology Group 6
- **XW033F6** Introduction of **Bamlanivimab** Monoclonal Antibody into **Peripheral Vein**, Percutaneous Approach, New Technology Group 6
- **XW043F6** Introduction of **Bamlanivimab** Monoclonal Antibody into **Central Vein**, Percutaneous Approach, New Technology Group 6

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NEW ICD-10-PCS CODES EFFECTIVE 1/1/21

Monoclonal Antibody

- **XW033G6** Introduction of **REGN-COV2** Monoclonal Antibody into **Peripheral Vein**, Percutaneous Approach, New Technology Group 6
- **XW043G6** Introduction of **REGN-COV2** Monoclonal Antibody into **Central Vein**, Percutaneous Approach, New Technology Group 6
- **XW033H6** Introduction of **Other** New Technology Monoclonal Antibody into **Peripheral Vein**, Percutaneous Approach, New Technology Group 6
- **XW043H6** Introduction of **Other** New Technology Monoclonal Antibody into **Central Vein**, Percutaneous Approach, New Technology Group 6
- **XW013H6** Introduction of **Other** New Technology Monoclonal Antibody into **Subcutaneous Tissue**, Percutaneous Approach, New Technology Group 6

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NEW ICD-10-PCS CODES EFFECTIVE 1/1/21

Other Drugs to Treat COVID

- **XW0DXM6** Introduction of **Baricitinib** into **Mouth and Pharynx, External Approach**, New Technology Group 6
- **XW0G7M6** Introduction of **Baricitinib** into **Upper GI, Via Natural or Artificial Opening**, New Technology Group 6
- **XW0H7M6** Introduction of **Baricitinib** into **Lower GI, Via Natural or Artificial Opening**, New Technology Group 6
- **XW043L6** Introduction of **CD24Fc Immunomodulator** into **Central Vein**, Percutaneous Approach, New Technology Group 6
- **XW033L6** Introduction of **CD24Fc Immunomodulator** into **Peripheral Vein**, Percutaneous Approach, New Technology Group 6

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COVID PPS UPDATES

Effective January 1, 2021

- Medicare will pay COVID-19 vaccines and the administration (separate from DRG rate).
- Report PCS and CPT codes when vaccine is provided during hospital inpatient stay
- Interim Rule:
  - October 28, 2020Medicare Part B Coverage and Payment of COVID-19 vaccination/administration
  - Add-On Payment for cases involving new COVID-19 treatments under the Medicare IPPS

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HCPCS G Code Update

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G0088	ADD	Adm iv drug 1st home visit	Professional services, initial visit, for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes
G0089	ADD	Adm subq drug 1st home visit	Professional services, initial visit, for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes
G0090	ADD	Adm iv chemo 1st home visit	Professional services, initial visit, for the administration of intravenous chemotherapy or other highly complex infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes
G2173	ADD	Uri w comorb 12m oth dx	Uri episodes where the patient had a competing comorbid condition during the 12 months prior to or on the episode date (e.g., tuberculosis, neutropenia, cystic fibrosis, chronic bronchitis, pulmonary edema, respiratory failure, rheumatoid lung disease)

https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G2174	ADD	Uri new rx antibiotic 30d	Uri episodes when the patient had a new or refill prescription of antibiotics (table 1) in the 30 days prior to or on the episode date
G2175	ADD	Pt comorb dx 12m of epi	Episodes where the patient had a competing comorbid condition during the 12 months prior to or on the episode date (e.g., tuberculosis, neutropenia, cystic fibrosis, chronic bronchitis, pulmonary edema, respiratory failure, rheumatoid lung disease)
G2176	ADD	Outpt ed obs w inpt admit	Outpatient, ed, or observation visits that result in an inpatient admission
G2177	ADD	Bronch w rx antibx 30d	Acute bronchitis/bronchiolitis episodes when the patient had a new or refill prescription of antibiotics (table 1) in the 30 days prior to or on the episode date
G2178	ADD	Pt not elig low neuro ex	Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee; patient has condition that would not allow them to accurately respond to a neurological exam (dementia, alzheimer's, etc.); patient has previously documented diabetic peripheral neuropathy with loss of protective sensation

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G2179	ADD	Med doc rsn no low ex	Clinician documented that patient had medical reason for not performing lower extremity neurological exam
G2180	ADD	Inelig footwr eval	Clinician documented that patient was not an eligible candidate for evaluation of footwear as patient is bilateral lower extremity amputee
G2181	ADD	Bmi not doc medrsn ptref	Bmi not documented due to medical reason or patient refusal of height or weight measurement
G2182	ADD	Pt 1st biolog antirheum	Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy
G2183	ADD	Doc pt unable comm	Documentation patient unable to communicate and informant not available
G2184	ADD	No caregiver	Patient does not have a caregiver
G2185	ADD	Caregiver dem trained	Documentation caregiver is trained and certified in dementia care

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G2186	ADD	Pt ref app rsrcs	Patient /caregiver dyad has been referred to appropriate resources and connection to those resources is confirmed
G2187	ADD	Clin ind img hd trauma	Patients with clinical indications for imaging of the head: head trauma
G2188	ADD	Pt 50 yrs w/clin ind hd	Patients with clinical indications for imaging of the head: new or change in headache above 50 years of age
G2189	ADD	Img hd abnml neuro exam	Patients with clinical indications for imaging of the head: abnormal neurologic exam
G2190	ADD	Ind img hd rad neck	Patients with clinical indications for imaging of the head: headache radiating to the neck
G2191	ADD	Ind img hd pos hd ache	Patients with clinical indications for imaging of the head: positional headaches

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G2192	ADD	>55 yrs temp hd ache	Patients with clinical indications for imaging of the head: temporal headaches in patients over 55 years of age
G2193	ADD	<6yr new onset hd ache	Patients with clinical indications for imaging of the head: new onset headache in pre-school children or younger (<6 years of age)
G2194	ADD	New hdache ped pt dis	Patients with clinical indications for imaging of the head: new onset headache in pediatric patients with disabilities for which headache is a concern as inferred from behavior
G2195	ADD	Occip hdache child	Patients with clinical indications for imaging of the head: occipital headache in children
G2196	ADD	Screen unhlthy etoh use	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G2197	ADD	Screen hlthy etoh use	Patient screened for unhealthy alcohol use using a systematic screening method and not identified as an unhealthy alcohol user
G2198	ADD	Med rsn no unhlthy etoh	Documentation of medical reason(s) for not screening for unhealthy alcohol use using a systematic screening method (e.g., limited life expectancy, other medical reasons)
G2199	ADD	Not scrn etoh no rsn	Patient not screened for unhealthy alcohol use using a systematic screening method, reason not given
G2200	ADD	Unhlthy etoh rcvd couns	Patient identified as an unhealthy alcohol user received brief counseling
G2201	ADD	Med rsn no brief couns	Documentation of medical reason(s) for not providing brief counseling (e.g., limited life expectancy, other medical reasons)

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G2202	ADD	No rsn no brief couns	Patient did not receive brief counseling if identified as an unhealthy alcohol user, reason not given
G2203	ADD	Med rsn no etoh couns	Documentation of medical reason(s) for not providing brief counseling if identified as an unhealthy alcohol user (e.g., limited life expectancy, other medical reasons)
G2204	ADD	Pt 50-85 w/ scope	Patients between 50 and 85 years of age who received a screening colonoscopy during the performance period
G2205	ADD	Preg drng adjv trtmt	Patients with pregnancy during adjuvant treatment course
G2206	ADD	Adjv trtmt chemo her2	Patient received adjuvant treatment course including both chemotherapy and her2-targeted therapy

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G2207	ADD	Rsn no trtmt chem her2	Reason for not administering adjuvant treatment course including both chemotherapy and her2-targeted therapy (e.g. poor performance status (ecog 3-4; karnofsky =50), cardiac contraindications, insufficient renal function, insufficient hepatic function, other active or secondary cancer diagnoses, other medical contraindications, patients who died during initial treatment course or transferred during or after initial treatment course)
G2208	ADD	No trtmt chemo and her2	Patient did not receive adjuvant treatment course including both chemotherapy and her2-targeted therapy
G2209	ADD	Refused to participate	Patient refused to participate
G2210	ADD	No neck fs prom no rsn	Risk-adjusted functional status change residual score for the neck impairment not measured because the patient did not complete the neck fs prom at initial evaluation and/or near discharge, reason not given

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G2211	ADD	Complex e/m visit add on	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
G2212	ADD	Prolong outpt/office vis	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report g2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (do not report g2212 for any time unit less than 15 minutes)

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G2213	ADD	Initiat med assist tx in er	Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services (list separately in addition to code for primary procedure)
G2214	ADD	Init/sub psych care m 1st 30	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional
G2215	ADD	Home supply nasal naloxone	Take-home supply of nasal naloxone (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G2216	ADD	Home supply inject naloxon	Take-home supply of injectable naloxone (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure
G2250	ADD	Remot img sub by pt, non e/m	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment

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JANUARY 2021 HCPCS G CODE CHANGES

HCPC	ACTION CD	SHORT DESCRIPTION	LONG DESCRIPTION
G2251	ADD	Brief chkin, 5-10, non-e/m	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5?10 minutes of clinical discussion
G2252	ADD	Brief chkin by md/qhp, 11-20	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

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Questions?

https://lh3.googleusercontent.com/proxy/ChaJJ28DSIuFP_ITcDKG_cp8BFSPOXk-pHPRZfDSB1EXeDrMmswx3ED0LMCF239YSS7n8NSPFqntrnY-kjDhEHFeiNX5YKEI3BC0jIueTrinVK6kxRnW3LRdDehFqCGyN-YWgdXrAqSNWp-dxRZDE1CkxfXkFKK1CUAQFRsiRu

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RESOURCES

- CMS Fact Sheet CY 2021 OPPS Final Rule
- CMS CY 2021 Final OPPS Rule and Files
- AMA CPT COVID Coding Guidance
- AHA COVID FAQ for ICD-10
- AMA MDM Table 2 Grid
- AMA E/M Office or Other Outpatient and Prolonged Services Guidelines
- HCPCS Quarterly Update

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