Long Island Health Information Management Association
CY 2020 OPPS & CPT Update

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2020 CPT, HCPCS, & OPPS Updates

Agenda

- CPT Changes
  - Integumentary System
  - Musculoskeletal System
  - Cardiovascular System
  - Digestive System
  - Nervous System
  - Eye & Ocular Adnexa
- Other Surgical CPT Changes
- New Category III Codes
- Other CPT Changes
- HCPCS Changes
- E/M Changes

- OPPS Changes
  - Comprehensive APCs (C-APC)
  - Changes to the Inpatient Only List
  - Pass-Through Devices
  - Modifier Changes
  - Prior Authorization for Certain HOPD Services
  - Hospital Outpatient Quality Reporting (OQR) Program

Code	CPT	HCPCS
New	249	289
Deleted	71	99
Description Change	75	88
Total	395	476

Integumentary System

http://integritydermatology.com/wp-content/uploads/2018/04/wordcloud.png

Repair Definitions

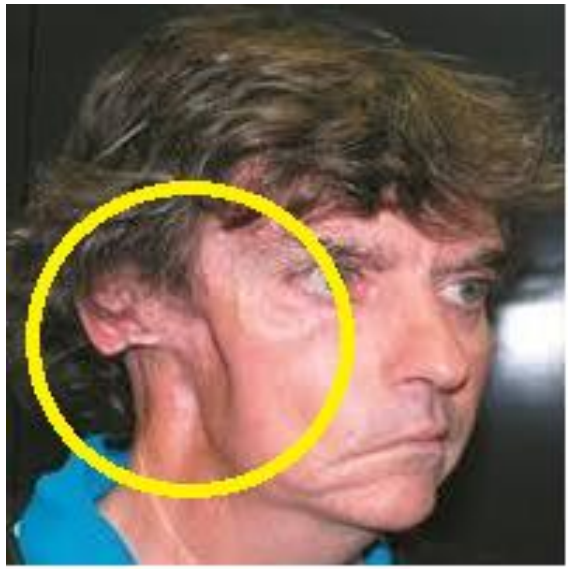
- New definition for Intermediate repair (12031-12057), added language for:
  - Includes Limited Undermining
    - Defined as a distance less than the maximum width of the defect measured perpendicular to the closure line, along at least one entire edge of the defect.
- Complex Repair clarification (13100-13160)
  - Exposure of bone, cartilage, tendon, or named neurovascular structure
  - Debridement of wound edges
  - Extensive undermining (Involvement of free margins of helical rim, vermilion border, or nostril rim)
    - Distance greater than or equal to the maximum width of the defect, measured perpendicular to the closure line along at least one entire edge of the defect
  - Placement of retention sutures

Fat Grafting

- **New Codes:**
- 15769 Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)
  - Excision
  - Used for reconstruction
- Fat Grafting (15771, 15772, 15773, and 15774)
  - 15771 & 15772: reported for fat harvested via liposuction for defects of the trunk, breasts, scalp, arms, and/or legs
  - 15771 -50 ccs or less
  - +15772 -add-on code for each additional 50 ccs or part thereof
  - 15773 & 15774: reported for fat harvested via liposuction for defects of the face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet
  - 15773 -25 ccs or less
  - +15774 -add-on code for each additional 25 ccs or part thereof
- +15777: Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)
  - Code twice for both breasts, do not use 50

Clinical Example 15769

- A 58 year old male presents with a left-sided parotid mass. The mass is excised, leaving a defect in the parotid bed. An en bloc fat graft is planned to correct the soft-tissue deficiency.



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Clinical Example 15769

- Operative Report
- The physician made an incision, followed by meticulous dissection and preparation of the recipient bed and facial nerve identification. The margins we re-excised from the previous incision, and debridement and removal of fibrous and poorly vascularized tissue was done. Hemostasis was obtained and the wound was packed with wet sponges.
- Graft planning and measurement was carried out for the needed graft size. The donor site was carefully re-measured and marked. An elliptical abdominal incision was made, just through the epithelium. The surgeon fastidiously removed all of the epithelium from the dermis. An elliptical incision was made again, but through the dermis and subcutaneous tissue for the second time around.

Clinical Example 15769

- Perform a dissection deep to the subcutaneous tissues. The graft was removed and set aside in saline for later implantation. The wound was undermined and closed primarily in three separate layers. The sponges were removed from the recipient wound and the site was re-inspected. The donor abdominal dermis and fat was trimmed to fill the defect, and placed en bloc into the defect to fill the soft-tissue void. The graft was fixed in place with long-lasting absorbable sutures. A drain was brought out and sutured into place. The wound was closured in a layered fashion.

Breast Procedures

- New guidelines for breast biopsy procedures to clarify breast biopsy procedures performed percutaneously or by open approach and with or without imaging. See CPT page 105.
- New guidelines in the Mastectomy Procedures subsection; Mastectomy Procedure subsection guidelines have been updated (CPT page 108) to describe the codes and provide guidance on how to report bilateral procedures.
- Parenthetical notes have been added following code 19303 to clarify reporting breast-size reduction for gynecomastia (19300) and breast size reduction for other than gynecomastia (19318).

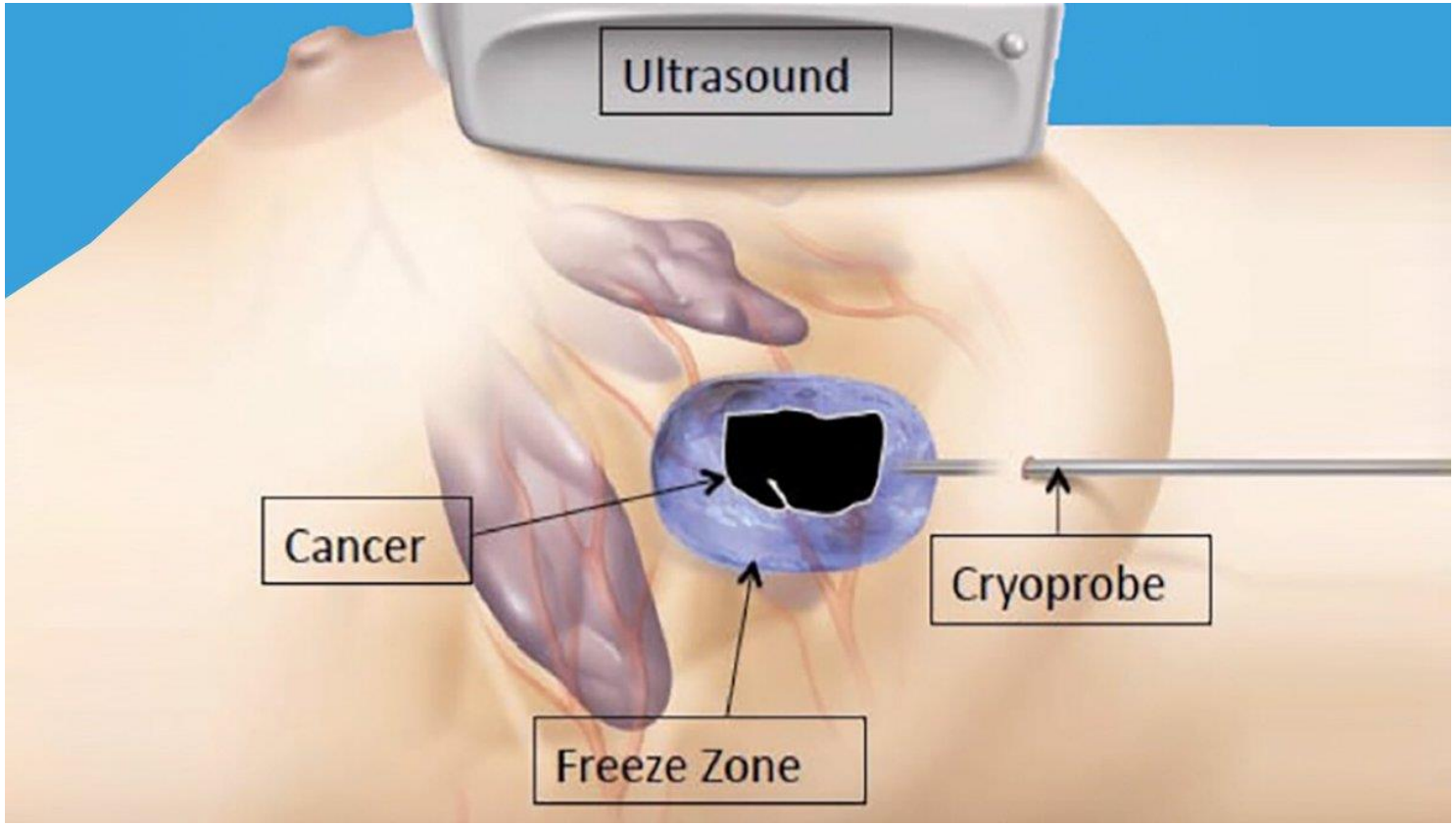
Breast Procedures

- Revised guidelines in Breast/Introduction subsection. The Introduction guidelines (CPT page 107) have been revised to clarify the codes in this subsection and for consistency and in support of the changes in the guidelines for the breast biopsy procedures.
- In addition, the guidelines also provide instruction on how to report add-on services and placement of radiotherapy catheters (afterloading expandable or afterloading brachytherapy).

Breast Procedures

- Deleted Mastectomy Code
  - 19304 Mastectomy, subcutaneous
  - Deleted due to low utilization
- New Technology Code
  - 0581T: Ablation, malignant breast tumor(s), percutaneous, cryotherapy
  - Reported only once per breast treated
  - Cryoablation of fibroadenoma(s) assigned to 19105

Cryoablation of Breast



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Musculoskeletal System

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Drug Delivery System

Drug Delivery –New Codes (**All are Add-On codes**)

- Prep and implant –Mixing and Preparing antibiotics (or other therapeutic agents) for delivery device (ex. Beads, nails, spacers)
  - Once per location
  - Not for prefabricated devices
- Device into subfascial, intramedullary or intraarticular spaces
  - 20700: Manual preparation and insertion of drug delivery device(s), deep (e.g.. Subfascial)
  - 20701: Removal (deep)
  - 20702: Manual preparation and insertion intramedullary)
  - 20703: Removal (intramedullary)
  - 20704: Manual preparation and insertion (intraarticular)
  - +20705: Removal (intraarticular)

Chest Wall Excisions

Excision

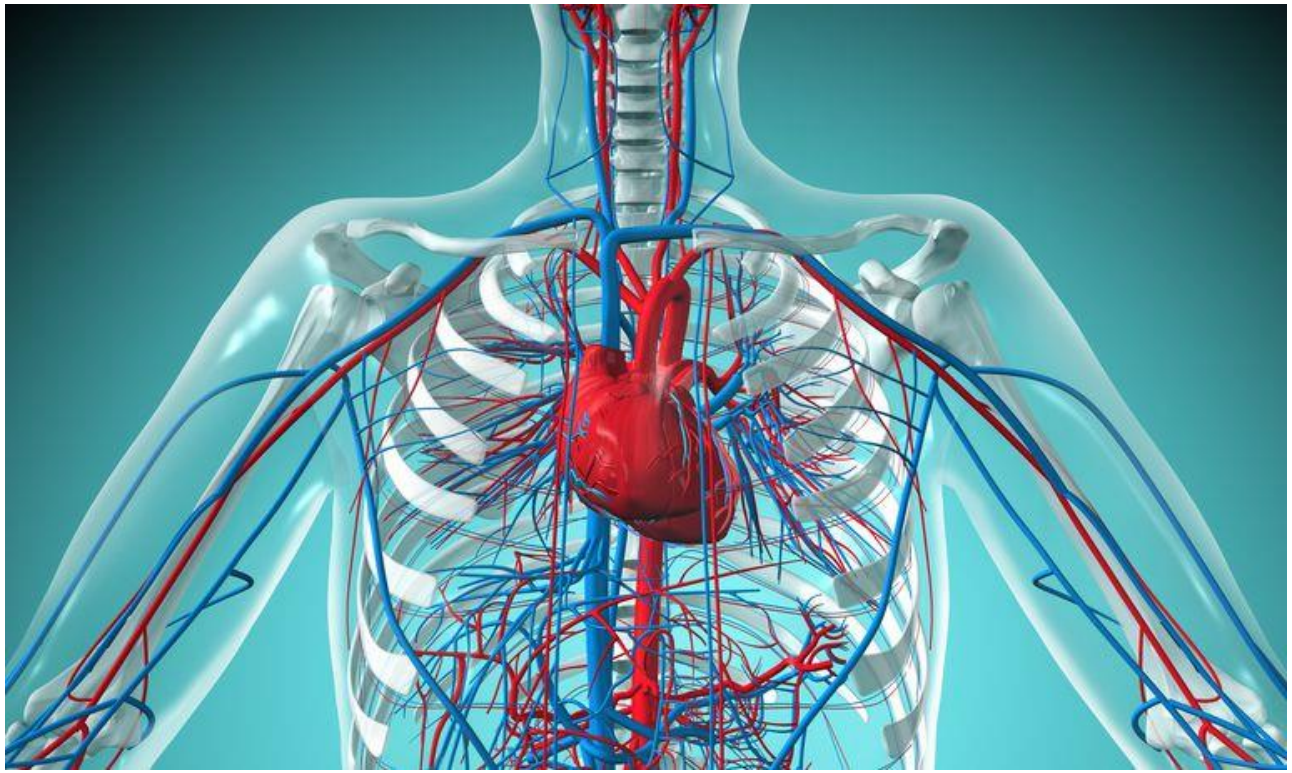
- Chest wall tumors
- Moved from Integumentary System
  - Codes 19260, 19271, and 19272 were deleted
- 21601 –21603
  - 21601: Excision of chest wall tumor including rib(s)- Status indicator J1
  - 21602: Excision of chest wall tumor involving rib(s), **with** plastic reconstruction; **without** mediastinal lymphadenectomy- status indicator C (IP only)
  - 21603: Excision of chest wall tumor involving rib(s), **with plastic** reconstruction; **with** mediastinal lymphadenectomy- status indicator C (IP Only)

Surgical

New Codes

- Trigger point acupuncture
- 20560 Needle insertion(s) without injection; 1 or 2 muscle(s)
- 20561 Needle insertion(s) without injection; 3 or more muscles
- Both codes are Status E1 and not covered by Medicare

Cardiovascular System



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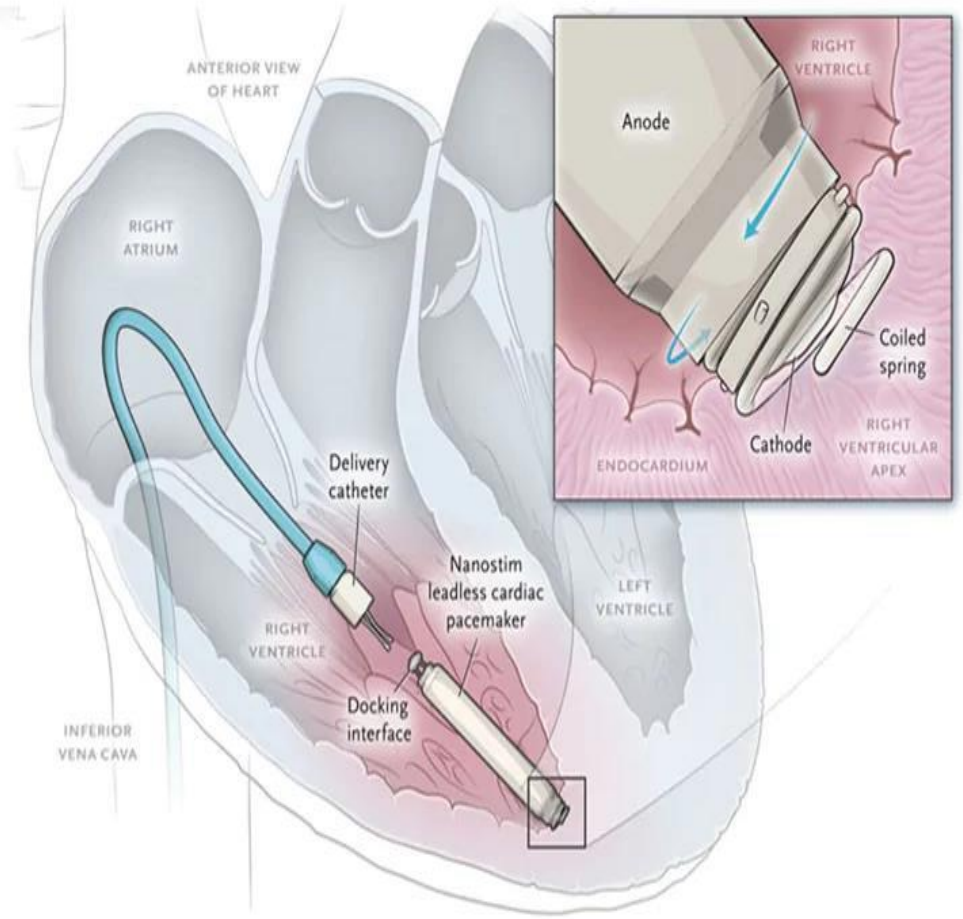
Pericardiocentesis

- 33010, 33011 & 33015 have been deleted
- New codes for drainage –include different types of imaging, age of patient is a factor in code choice and with/without congenital cardiac issues is defined.
- The indwelling catheter is not always left in for drainage procedures
  - 33016: Pericardiocentesis, including imaging guidance, when performed (catheter not left in)- status indicator J1
  - 33017: Pericardial drainage with insertion of indwelling catheter, percutaneous, **including fluoroscopy and/or ultrasound guidance**, when performed; 6 years and older without congenital cardiac anomaly (catheter left in)- status indicator C (IP only)
  - 33018: Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; birth through 5 years of age or any age **with** congenital cardiac anomaly (catheter left in)- status indicator C (IP only)
  - 33019: Pericardial drainage with insertion of indwelling catheter, percutaneous, **including CT guidance** (catheter left in)- status indicator C (IP only)

Leadless Pacemaker Revision

- Leadless Pacemaker Revision
- 33275 Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed



Implantable Cardioverter Defibrillator and Substernal Electrode

- New Category III Codes
- Implantable Cardioverter Defibrillator and Substernal Electrode
  - 0571T: Insertion or replacement system
  - 0572T: Insertion electrode
  - 0573T: Removal electrode
  - 0574T: Repositioning
  - 0575T: Programming
  - 0576T-0579T: Device Evaluation
  - 0580T: Removal generator
- Image guidance included

Implantable Cardioverter Defibrillator and Substernal Electrode

- 3 Types of Implantable Defibrillators in CPT
  1. Transvenous implantable pacing cardioverter-defibrillator
  2. Subcutaneous implantable defibrillator
  3. Substernal implantable cardioverter-defibrillator
  - Lead is tunneled and placed in the substernal anterior mediastinum, without entering the pericardial cavity.

Aortic Grafts

New Codes: Inpatient Only

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

Iliac Artery Endovascular Repair

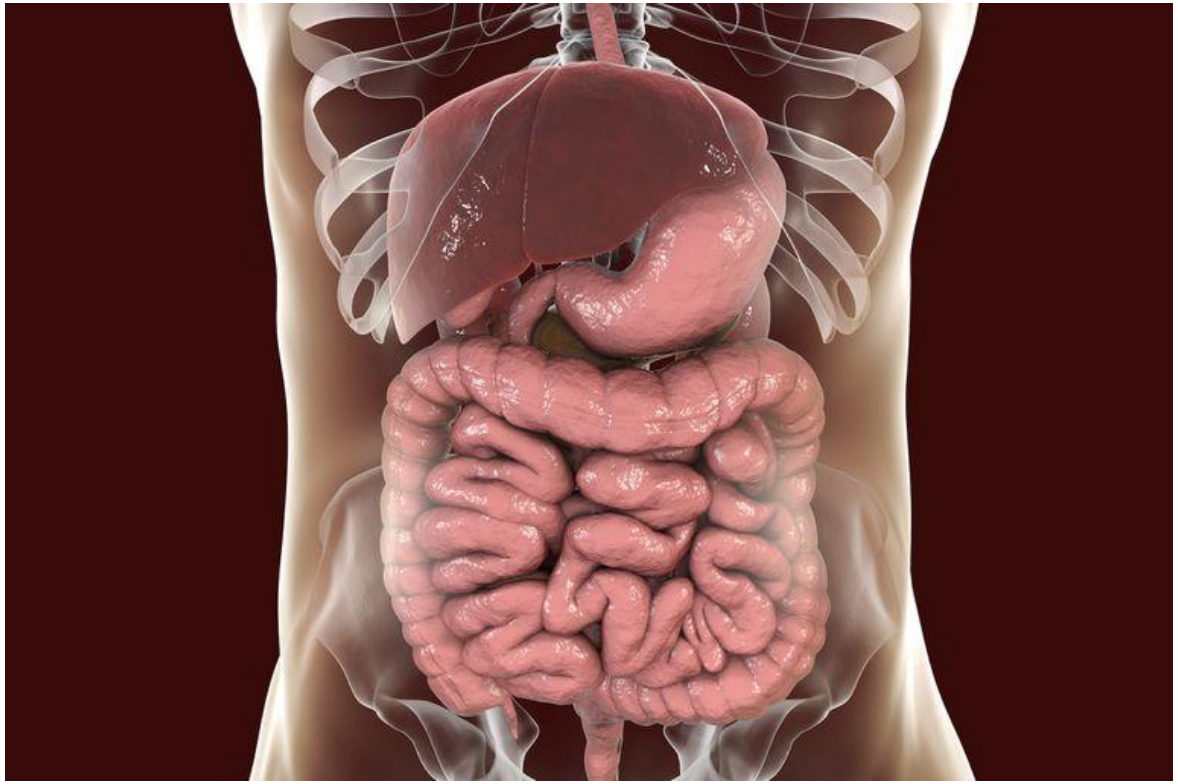
New Codes: Inpatient Only

- 34717: Performed at the time of aortoiliac artery endograft placement (Add-On Code)
- 34718: Not associated with placement of an aorto-iliac endograft at the same session (Stand-Alone code)

Exploration Of Artery

- 1 code revised and 2 new codes
- 3 deleted codes (35721: femoral artery, 35741: popliteal artery, 35761: other vessels)
  - 35701: Exploration not followed by surgical repair, artery; neck (eg.carotid, subclavian) –Revised text
  - 35702: Upper extremity (eg, axillary, brachial, radial ulnar) –New Code
  - 35703: Lower extremity (eg, common femoral, deep femoral, superficial femoral, popliteal, tibial, peroneal) –New Code
- All codes are inpatient only (SI C)

Digestive System



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Hemorroidectomy

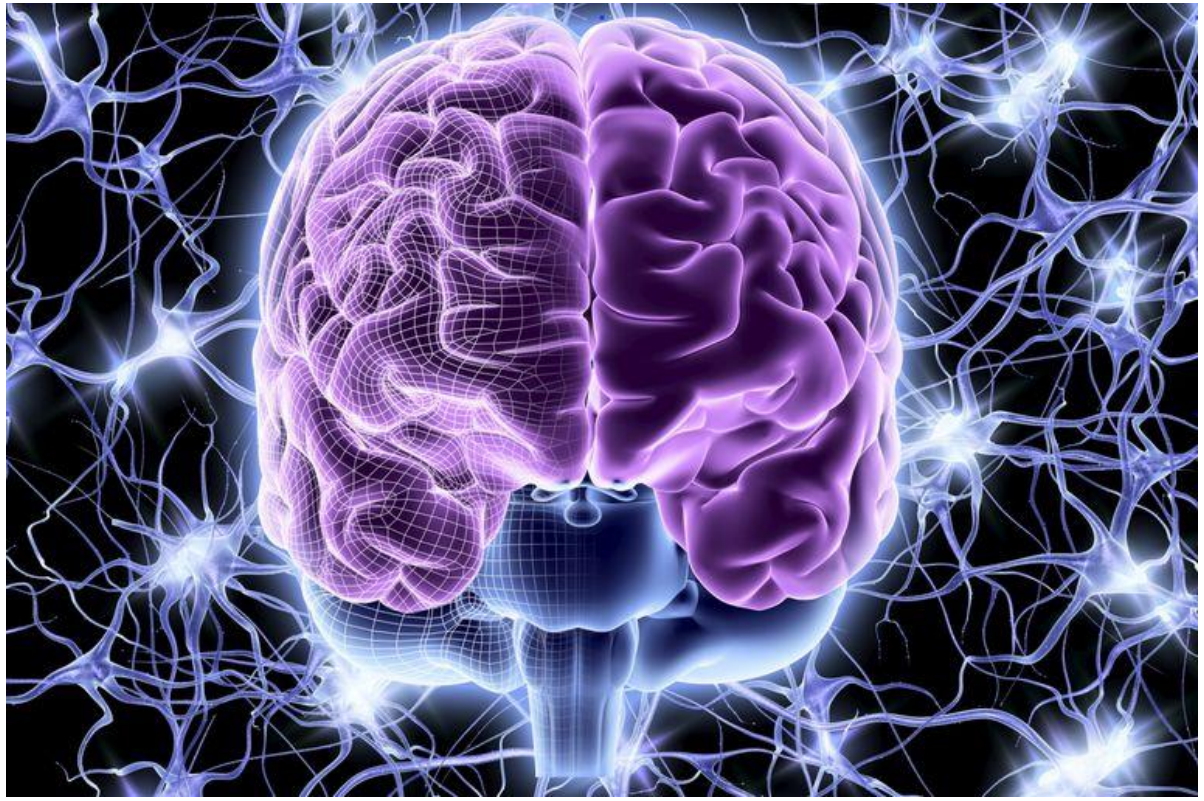
- Revised Hemorrhoidectomy Procedures
  - 46945: Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group, without imaging guidance
  - 46946: 2 or more hemorrhoid columns/groups, without imaging guidance
- New Hemorrhoidectomy code
  - 46948: Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy , when performed
  - Used to be assigned to category III code 0249T

Pelvic Packing

New Codes: Inpatient Only (SI C)

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

Nervous System



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Spinal Punctures

- Revised
  - 62270: Spinal puncture, Lumbar, Diagnostic;
  - 62272: Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);
- New
  - 62328: Spinal puncture, Lumbar, Diagnostic; with fluoroscopic or CT Guidance
  - 62329: Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT Guidance

Nerve Injections

- Nerve Injection Revisions
- Base Code 64400: Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, **each branch (ophthalmic, maxillary, mandibular)**
- All codes in the family include the same editorial changes. The codes revised are 64405, 64408, 64416, 64417, 64418, 64425, 64430, 64435, 64446, 64448, 64449, and 64450

Nerve Injections

- Nerve Injection Revisions
  - 64415: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus
  - 64420: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level
  - +64421: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (List separately in addition to code for primary procedure)
  - 64445: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve
  - 64447: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve

Nerve Injections

►Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System			
Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic			
Code(s)	**Unit**	**Image Guidance Included**	**Image Guidance Separately Reported, When Performed**
Somatic Nerve			
64400-64450	1 unit per plexus, nerve, or branch injected regardless of the number of injections		X
64451	1 unit for any number of nerves innervating the sacroiliac joint injected regardless of the number of injections	X	
64454	1 unit for any number of genicular nerve branches, with a required minimum of three nerve branches	X	
64455	1 or more injections per level		X
64479	1 or more injections per level	X	
+64480	1 or more additional injections per level (add-on)	X	
64483	1 or more injections per level	X	
+64484	1 or more additional injections per level (add-on)	X	
64461	1 injection site	X	
+64462	1 or more additional injections per code (add-on)	X	
64463	1 or more injections per code	X	
64486-64489	By injection site	X	
Destruction by Neurolytic Agent (Eg, Chemical, Thermal, Electrical, or Radiofrequency), Chemodenervation			
Code(s)	**Unit**	**Image Guidance Included**	**Image Guidance Separately Reported, When Performed**
Somatic Nerves			
64624	1 unit for any number of genicular nerve branches, with a required minimum of three nerve branches	X◄	

AMA 2020 CPT Book pg. 437

Nerve Injections

- 2 New Nerve **Injection** Codes
  - 64451: Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)
  - 64454: Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed
- 2 New Nerve **Destruction** Codes
  - 64624: Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed
  - 64625: Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)

Nerve Injections

- Codes 64402, 64410, 64413 have been deleted.
  - Deleted because they are not commonly performed.
- To report the injection of anesthetic agent and/or steroid to the facial, phrenic, and/or cervical nerves, use code 64999.

Eye & Ocular Adnexa

https://www.altru.org/app/files/public/18218/Eye-banner.jpg

Cataract Surgery

- Endoscopic Cyclophotocoagulation (without cataract extraction) –Revised
  - 66711: Ciliary body destruction; cyclophotocoagulation, endoscopic, **without concomitant removal of crystalline lens (For glaucoma only)**
  - 66982: **without endoscopic cyclophotocoagulation**
  - 66984: **without endoscopic cyclophotocoagulation**
- New Codes
  - 66987: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; **with endoscopic cyclophotocoagulation** (extracapsular complex for glaucoma and cataract)
  - 66988: Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); **with endoscopic cyclophotocoagulation**

Other Surgical Changes

- Nasal/Sinus Endoscopy
  - Revised codes in the nasal endoscopy to a common language
  - Moved the sinusoscopy to after the semicolon (;) from the parent code 31233
  - Changed “same sinus” to “ipsilateral side”
- Orchiopexy
  - Revised 54640 Orchiopexy, inguinal or scrotal approach
  - Revised by deleting “with or without hernia repair”.
  - This revision now allows the separate reporting of inguinal hernia repair when performed.

New Category III Codes

- Continence Device Procedures (Status J1)
  - 0548T: Transperinealperiurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy
  - 0549T: Transperinealperiurethral balloon continence device; unilateral placement, including cystoscopy and fluoroscopy
  - 0550T: Transperinealperiurethral balloon continence device; removal each balloon
  - 0551T: Transperinealperiurethral balloon continence device; adjustment of balloon(s) fluid volume (Status T)

New Category 3 Codes

- Destruction of Prostate Tissue (Status E1)
  - 0582T: Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance

Other CPT Changes

- Radiology 70010-7999
  - 12 New Codes
  - 18 Revised Codes
  - 15 Deleted Codes
- Pathology and Laboratory 80047-0017U
  - 14 New Codes
  - 4 Revised Codes
  - 0 Deleted Code
- Anesthesia
  - No changes except for status indicator of 4 codes from C (inpatient only) to N (packaged)

HCPCS Changes

HCPCS II Alpha	HCPCS II Description	Additions	Revisions	Deletions	Total Changes
A	Transportation Services, including Ambulance; Med/Surg Supplies	2	0	0	2
B	Enteral and Parenteral Therapy	1	1	0	2
C	Hospital Outpatient Prospective Payment System (devices and procedures)	13	0	17	30
D	Dental Procedures - ADA	37	18	6	61
E	Durable Medical Equipment	2	0	0	2
G	Temporary (Procedures & Professional Services)	131	45	65	241
H	Alcohol and Drug Abuse Treatment	0	0	0	0
J	Drugs Administered other than oral method	32	6	1	39
K	Temporary (DME)	5	0	0	5
L	Orthotics and Services; Prosthetics	2	1	0	3
M	Medical Services	39	12	10	61
P	Pathology and Lab Services	1	0	0	1
Q	Temporary (Procedures, Services and Supplies)	24	5	0	29
R	Diagnostic Radiology Services	0	0	0	0
S	Drugs, Services, Supplies – used by private insurers (non-Medicare)	0	0	0	0
T	For use by Medicaid State Agencies	0	0	0	0
V	Vision Services – may be found in the CDM for intraocular lens	0	0	0	0

Dental Changes

CODE	DESCRIPTION	ACTION	SI	APC PMT	REPLACEMENT
D0419	Assessment of salivary flow by measurement	NEW	E1		
D1550	Re-cement or re-bond space maintainer	DELETED	D		
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	NEW	S	974.97	
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	NEW	S	974.97	
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	NEW	S	974.97	
D1555	Procedure performed by dentist or practice that did not originally place the appliance.	DELETED	D		
D1556	Removal of fixed unilateral space maintainer - per quadrant	NEW	E1		
D1557	Removal of fixed bilateral space maintainer - maxillary	NEW	E1		
D1558	Removal of fixed bilateral space maintainer - mandibular	NEW	E1		
D2753	Crown - porcelain fused to titanium and titanium alloys	NEW	E1		
D5284	Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	NEW	E1		
D5286	Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant	NEW	E1		
D6082	Implant supported crown - porcelain fused to predominantly base alloys	NEW	E1		
D6083	Implant supported crown - porcelain fused to noble alloys	NEW	E1		

Dental Changes

CODE	DESCRIPTION	ACTION	SI	APC PMT	REPLACEMENT
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	NEW	E1		
D6086	Implant supported crown - predominantly base alloys	NEW	E1		
D6087	Implant supported crown - noble alloys	NEW	E1		
D6088	Implant supported crown - titanium and titanium alloys	NEW	E1		
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	NEW	E1		
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	NEW	E1		
D6099	Implant supported retainer for fpd - porcelain fused to noble alloys	NEW	E1		
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	NEW	E1		
D6121	Implant supported retainer for metal fpd - predominantly base alloys	NEW	E1		
D6122	Implant supported retainer for metal fpd - noble alloys	NEW	E1		
D6123	Implant supported retainer for metal fpd - titanium and titanum alloys	NEW	E1		
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	NEW	E1		
D6243	Pontic - porcelain fused to titanium and titanium alloys	NEW	E1		
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	NEW	E1		
D6784	Retainer crown 3/4 - titanium and titanium alloys	NEW	E1		

Dental Changes

CODE	DESCRIPTION	ACTION	SI	APC PMT	REPLACEMENT
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	NEW	E1		
D8691	Does not include bracket and standard fixed ortho appliances. It does include functional appliances and palatal expanders.	DELETED	D		
D8692	Replacement of lost or broken retainer	DELETED	D		
D8693	Re-cement or re-bond fixed retainer	DELETED	D		
D8694	Repair of fixed retainers, includes reattachment	DELETED	D		
D8696	Repair of orthodontic appliance - maxillary	NEW	E1		
D8697	Repair of orthodontic appliance - mandibular	NEW	E1		
D8698	Re-cement or re-bond fixed retainer - maxillary	NEW	E1		
D8699	Re-cement or re-bond fixed retainer - mandibular	NEW	E1		
D8701	Repair of fixed retainer, includes reattachment - maxillary	NEW	E1		
D8702	Repair of fixed retainer, includes reattachment - mandibular	NEW	E1		
D8703	Replacement of lost or broken retainer - maxillary	NEW	E1		
D8704	Replacement of lost or broken retainer - mandibular	NEW	E1		
D9997	Dental case management - patients with special health care needs	NEW	E1		

Evaluation and Management

https://sandhillssentinel.com/wp-content/uploads/2018/06/doctor-seeing-child-patient.jpg

Evaluation & Management

- New Online Digital E/M Codes 99421-99423
  - Intended for patient-initiated digital communications that require a clinical decision that would have been typically provided in the office.
  - Time based
  - Does not include electronic communication of lab results, medication requests, or scheduling of appointments.
- Deleted 99444 Online E/M service

Evaluation & Management

- Telephone Services 99441-99443
  - Non-face-to-face E/M services provided to a patient using the telephone by a physician or other qualified healthcare professional who may report E/M services.
  - Established patient (or guardian) initiated

2019	2020
(Do not report 99441-99443 if 99441-99444 have been reported by the same provider in the previous seven days.)	(Do not report 99441-99443, if 99421, 99422, 99423 have been reported by the same provider in the previous seven days for the same problem.)

Evaluation & Management

- Remote Physiologic Monitoring Treatment Management Services
  - The guidelines for this subsection that was new for 2019 were revised as have been code 99457 to report remote physiologic monitoring treatment management services for the first 20 minutes of service.
  - A new add-on code, 99458, has been established to report each additional 20 minutes of remote physiologic monitoring treatment management services.
  - Neither code may be reported if the service is less than 20 minutes.

Evaluation & Management

- Digitally Stored Data Services
  - The guidelines for this section have been revised to include new code 99474 and to indicate that it should not be reported separated with an E/M service on the same day by the same provider when measured blood pressure (BP) monitoring is performed.
  - 99473 and 99474 have been established to report self-measured BP monitoring using a device that has been validated for clinical accuracy.
  - 99473 includes patient education and training on device calibration, which is typically performed by a care-team member and should only be reported **once per device.**
  - 99474 is reported for reviewing individual readings, averaging the readings, and providing instructions to the clinical staff on what should be communicated to the patient –**once per calendar month.**

Evaluation & Management

- The United States Preventive Services Task Force (USPSTF) released updated recommendations for screening of high BP and determined that reliance on BP measurement in a clinical setting can result in measurement errors.
- To report remote physiological monitoring the device must be a medical device as defined by the FDA and the service must be ordered by a physician or other qualified health care professional.

Medicare Outpatient Prospective Payment System

Payment Rule Brief — Calendar Year 2020 Final Rule with Comment Period

Medicare Outpatient Prospective Payment System

The final rule includes policies that:

- The total 2020 increase in OPPS spending due only to changes in the 2020 OPPS rule is estimated to be approximately $1.21 billion ;
- The update to the conversion factor and the multifactor productivity adjustment will increase total OPPS payments by 2.6 percent in 2020; and
- Update payment rates and policies for Ambulatory Surgical Centers (ASCs).

Medicare Outpatient Prospective Payment System

	Final CY 2019	Final CY 2020	Percent Change
OPPS Conversion Factor	$79.490	$80.784	+1.60%

Comprehensive APCs (C-APCs) for 2020

- A C-APC is defined as a classification for a primary service and all adjunctive services provided to support the delivery of the primary service.
- When such a primary service is reported on a hospital outpatient claim, Medicare makes a single payment for that service and all other items and services reported on the hospital outpatient claim that are integral, ancillary, supportive, dependent, and adjunctive to the primary service.
- A single prospective payment is made for the comprehensive service based on the costs of all reported services on the claim.

2020 Comprehensive APCs

- For CY 2020, CMS created two new C-APCs, bringing to total number to 65 C-APCs:
  - C-APC 5182 Level 2 Vascular Procedures ;
  - C-APC 5461 Level 1 Neurostimulator and Related Procedures .

Changes to the Inpatient Only List

CY2020 CPT Code	Description	CY 2020 OPPS Status Indicator
27130	Total Hip Arthroplasty, acetabular and proximal femoral prosthetic replacement, with or without autograft or allograft	J1
22633	Lumbar Spinal Fusion Combined	J1
22634	each additional interspace and segment	N
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural, cervical	J1
63266	thoracic	J1
63267	lumbar	J1
63268	sacral	J1
00670	Anesthesia for extensive spine and spinal cord procedures on the cervica, thoracic, or lumbar spine	N
00802	Anesthesia for panniculectomy	N
00865	Anesthesia for radical prostetectomy (suprapubic, retropubic)	N
00944	Anesthesia for vaginal hysterectomy	N
01214	Anesthesia for radical resection of femur	N

Inpatient Only List

- The CY20 final rule removes total hip arthroplasty (CPT Code 27130) from the inpatient only list in CY20, allowing these procedures to be performed in hospital outpatient departments. It will be assigned to C-APC 5115 with a status indicator of J1.
- Quality Improvement Organizations are prohibited from referring THA cases performed in the inpatient setting to Recovery Audit Contractors for patient status (site of service) reviews for two years (increased from one year in the proposed rule).

Inpatient Only List

- The CY20 final rule removes Combined (anterior and posterior) Lumbar Spinal Fusions (CPT Code 22633) from the inpatient only list in CY20, allowing these procedures to be performed in hospital outpatient departments. It will be assigned to C-APC 5115 with a status indicator of J1.
  - Add-on code 22634 for each additional interspace and segment was also taken off the inpatient only list with a status indicator of N
- Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extra dural has also been removed from the inpatient only list with a status of J1 and to C-APC 5114
  - 63265 (lumbar)
  - 63266 (thoracic)
  - 63267 (lumbar)
  - 63268 (sacral)

2020 Pass-Through Devices

- There is one device eligible for pass-through status:
  - HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system), with an eligibility date of January 1, 2019.
  - The pass-through status of the device category for C2624 expires on December 31, 2021 and C1822 will continue to receive device pass-through payments in 2020.
- CMS added five more devices in the CY 2020 final rule under the traditional process:
- - Surefire® Spark™ Infusion System
- - Optimizer® System
- - AquaBeam and
- - AUGMENT® Bone Graft
- - ARTIFICALIris® was approved for pass-through status under the new, “Breakthrough Device Alternative Pathway:”

Add-on Code Guideline Change

- Modifiers 50 & 51 should not be appended to add-on codes
- List the add-on code twice if it is bilateral unless instructed differently –Do not use modifier -50
- Add-on codes are exempt from the multiple procedure concept

New Modifier

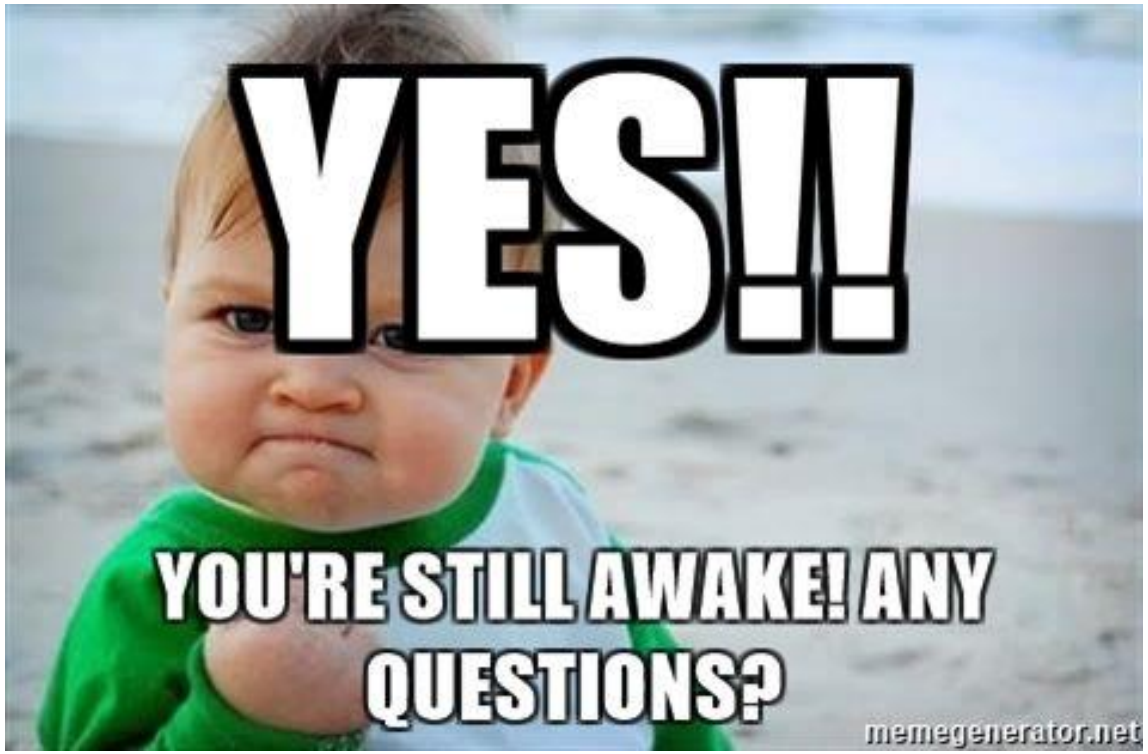
- Modifier 63: Procedure Performed on Infants less than 4kg (8.8lbs)
- For surgery codes plus listed cardio medicine codes
  - PCI, TEE, Cath, etc.
- Does not apply to E/M, Anesthesia, Radiology, Pathology/Lab, or Medicine, except as defined above.

Prior Authorization Process and Requirements for Certain HOPD Services

- CMS finalized its proposal to require prior authorization for the following five services to ensure they are billed only when medically necessary:
  1) blepharoplasty,
  2) botulinum toxin injections,
  3) panniculectomy,
  4) rhinoplasty and
  5) vein ablation.
- CMS may elect to exempt a provider from the prior authorization process upon a provider's demonstration of compliance with Medicare coverage, coding and payment rules. See Table 64, pg 1010 in the Final Rule for CPT codes

2020 Hospital Outpatient Quality Reporting (OQR) Program

- For the CY 2020 Hospital Outpatient Quality Reporting (OQR) Program, CMS will remove:
  - OP-33: External Beam Radiotherapy for Bone Metastases for the CY 2022 payment determination and subsequent years with modification.
- The rule (beginning with January 2020 encounters) removes OP-33 for the CY22 payment determination and subsequent years due to the cost associated with the measure relative to its benefits.



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