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CPAs & BUSINESS ADVISORS

2024 CPT CODE CHANGES

January 2023

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PRESENTERS

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BIOGRAPHY

- Director/Healthcare Consultant
- Been at Eide Bailly for 23 years
- Main focus is on Professional Coding/Documentation, Compliance, Medical Necessity
- All surgical specialties, focus on Interventional Radiology, Neurosurgery, Podiatry, Ortho, etc
- Evaluation and Management (E/M) proper documentation

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LEARNING OBJECTIVES

- Highlight the newest CPT code and guideline updates provided by the American Medical Association (AMA).
- Provide detailed review of the code and guideline changes related to sections that received the most updates.
- Q & A examples that demonstrate how the code updates apply in practice.

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Disclaimer: The information contained in these slides and presentation is current as of November 30, 2023.

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2024 CODE CHANGES

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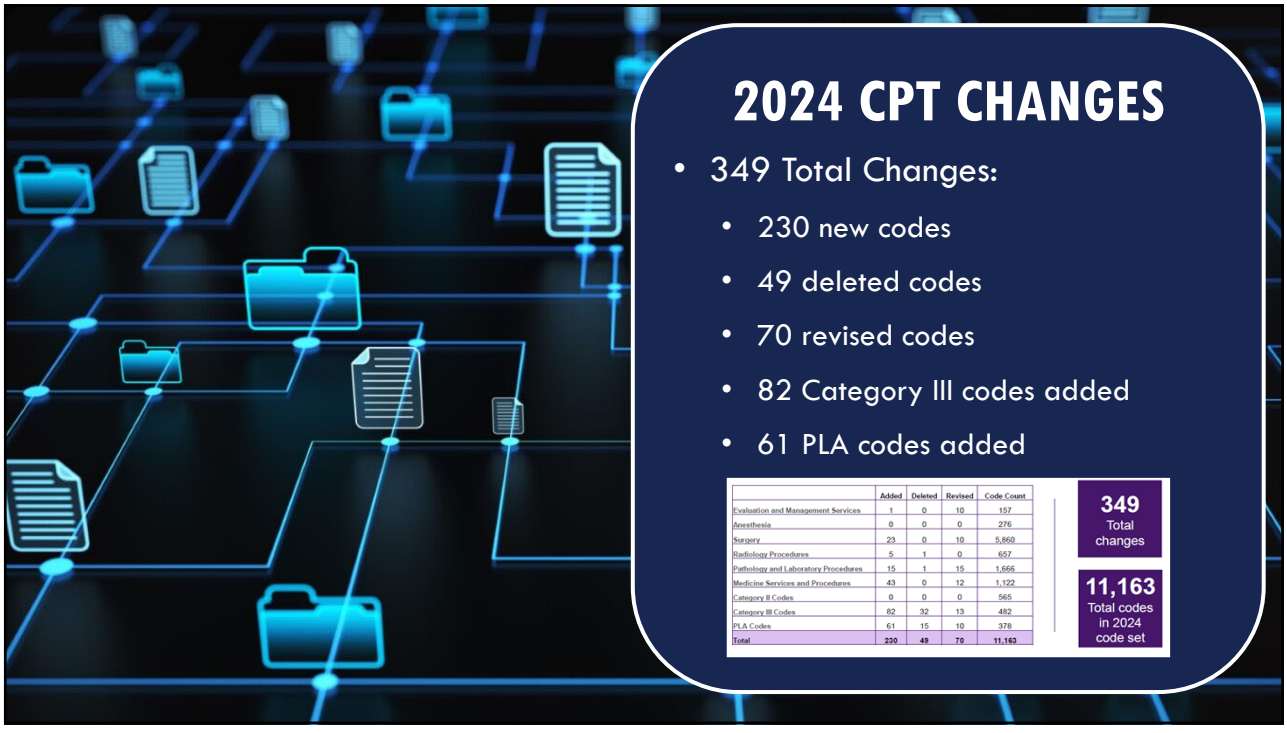

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MPFS FINAL RULE

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MPFS FINAL RULE HIGHLIGHTS

- Evaluation & Management Services
  - Split/Shared Visit guidance
- Telehealth and other services involving Communications Technology
- RPM/RTM
- Behavioral Health Services
- Social Determinants of Health (SDOH)
- Add On Complexity Code - G2211
- Conversion Factor
- RHC Provider Requirements

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CONVERSION FACTOR

- The PFS conversion factor is the number that translates RVUs into dollars.
- The Social Security Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million; if they do, CMS applies a budget neutrality adjustment. For CY 2024, the budget neutrality adjustment is -2.18 percent.
- Approximately 90% of the overall PFS budget neutrality adjustment is attributable to the proposal to implement a separate add-on payment for HCPCS code G2211. The remaining 10% is associated with other proposed changes in valuation of codes along with the third year of the clinical labor pricing update. We note that the clinical labor pricing update is responsible for significant shifting of spending between specialties, however these changes are reflected in the changes to the RVUs for individual services and do not affect the conversion factor.

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CONVERSION FACTOR

By factors specified in law, overall payment rates under the PFS will be reduced by 1.25% in CY 2024 compared to CY 2023. CMS is also finalizing significant increases in payment for primary care and other kinds of direct patient care.

The final CY 2024 PFS conversion factor is $32.74, a decrease of $1.15 (or 3.4%) from the current CY 2023 conversion factor of $33.89.

Note, to maintain budget neutrality in the 2024 MFS, CMS retained the balance in the work, practice expense (PE), and professional liability insurance (PLI) RVU pools, which in effect increased the PE and PLI RVU pools.

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CONVERSION FACTOR

Calculating the CY 2024 PFS conversion factors (CF)		
CY 2023 CF	**CY 2024 CF**	**YTY% change**
$33.8872	$32.7375	-3.4%
CY 2023 anesthesia CF	**CY 2024 anesthesia CF**	**YTY% change**
$21.1249	$20.4349	-3.3%

**Note: All rates are effective Jan. 1, 2024, according to the final 2024 Medicare physician fee schedule*

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SPECIALTY WINNERS

Specialty	Allowed charges (mil)	Impact of work RVU changes	Impact of PE RVU changes	Impact of MP RVU changes	Combined impact
Endocrinology	$509	1%	1%	0%	3%
Family practice	$5,538	2%	2%	0%	3%
Clinical psychologist	$717	1%	0%	0%	2%
Clinical social worker	$801	2%	0%	0%	2%
General practice	$368	1%	1%	0%	2%
Hematology/Oncology	$1,595	1%	0%	0%	2%
Nurse practitioner	$6,297	1%	1%	0%	2%
Physician assistant	$3,377	1%	1%	0%	2%
Psychiatry	$907	1%	1%	0%	2%
Rheumatology	$510	1%	1%	0%	2%

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SPECIALTY LOSERS

Specialty	Allowed charges (mil)	Impact of work RVU changes	Impact of PE RVU changes	Impact of MP RVU changes	Combined impact
Interventional radiology	$458	-1%	-3%	0%	-4%
Nuclear medicine	$51	-1%	-2%	0%	-3%
Physical/Occupational therapy	$5,281	-1%	-2%	0%	-2%
Radiology	$4,536	-1%	-2%	0%	-3%
Vascular surgery	$1,011	0%	-3%	0%	-3%
Anesthesiology	$1,650	-2%	-1%	0%	-2%
Audiologist	$69	-1%	-1%	0%	-2%
Cardiac surgery	$175	-1%	-1%	0%	-2%
Chiropractic	$649	-1%	-1%	0%	-2%
Colon and rectal surgery	$147	-1%	-1%	0%	-2%
Diagnostic testing facility	$833	0%	-1%	0%	-2%
Emergency medicine	$2,473	-2%	-1%	0%	-2%
Nurse anesthetist/Anesthesia assistant	$1,081	-2%	0%	0%	-2%
Optometry	$1,299	-1%	-1%	0%	-2%
Oral/Maxillofacial surgery	$63	-1%	-1%	0%	-2%
Pathology	$1,142	-1%	-1%	0%	-2%
Radiation oncology and radiation therapy centers	$1,556	0%	-2%	0%	-2%
Thoracic surgery	$293	-1%	-1%	0%	-2%

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BACKGROUND – COMPLEXITY CODE

- In 2021, CMS implemented G2211, *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)*,a new add-on code for complex patients that could be appended to any office and outpatient Evaluation and Management (E/M) code.
- CMS assumed G2211 would be a frequently utilized code (up to 90% of claims) that would have a significant impact on budget neutrality. G2211 accounted for an estimated $3.3 billion increase in PFS spending and a corresponding 3% cut to the RBRVS CF in 2021.
- Due to the potential reduction in payments for physicians who do not bill office and outpatient E/M services (think MDA/CRNA/Pain Management/Specialties that do minor procedures (derm/ortho/podiatry)), Congress delayed the implementation of G2211 until CY 2024.

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COMPLEXITY CODE

Beginning January 1, 2024, CMS is finalizing implementation of a separate add-on payment code G2211. This add-on code will better recognize the resource costs associated with evaluation and management visits for primary care and longitudinal care. Generally, it will be applicable for outpatient and office visits (99202-99215) as an additional payment, recognizing the inherent costs involved when clinicians are the continuing focal point for all needed services, or are part of ongoing care related to a patient's single, serious condition or a complex condition

For example, a primary care clinician, as the continuing focal point for all needed health care services for a patient, often bears the:

cognitive load,

responsibility,

and an accountability for building the most effective, trusting relationship possible amidst evaluating and managing other health care problems during a visit.

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G2211 – BUDGET NEUTRALITY

Implementing payment for this add-on code has redistributive impacts for all other CY 2024 payments under the Medicare Physician Fee Schedule, due to statutory budget neutrality requirements.

These redistributive impacts are comparatively less than what CMS initially estimated for this policy in CY 2021 when CMS originally finalized this policy in the CY 2021 Medicare Physician Fee Schedule final rule. At that time, Congress suspended the use of the add-on code by prohibiting CMS from making additional payment under the PFS for these inherently complex E/M visits before January 1, 2024. Since this policy will improve the accuracy of payment for primary and longitudinal care, CMS is finalizing implementation of the policy with certain modifications for 2024.

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G2211 – PAYMENT

The code will pay about $16 per claim after factoring in work, practice expense and malpractice relative value units (RVU).

CMS lowered its initial estimate of billing frequency for the add-on code, projecting that it will be reported on 38% of all office visit codes at the immediate outset. That number could rise to 54% of office visits once the provider community grows more comfortable with its use.

Cognitive work associated with providing longitudinal care to patients is underpaid, and that G2211 is intended to make up for part of the shortage.

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G2211 – EXAMPLES

- Patient has a primary care practitioner that is the continuing focal point for all health care services, and the patient sees this practitioner to be evaluated for sinus congestion.
- Complexity code, G2211, captures not only the clinical condition itself — sinus congestion — but rather the cognitive load of the continued responsibility of being the focal point for all needed services for this patient.
- Not eligible with modifier 25. As proposed, the add-on code will not be accepted with an E/M service reported with modifier 25 (Significant, separately identifiable E/M service).
- No specialties are excluded. CMS notes that this code is not restricted to medical professionals based on particular specialties.
- CMS reiterates that the add-on code should be reported "for care that serves 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.

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G2211 – EXAMPLE

A patient with HIV has an office visit with their infectious disease physician, who is part of ongoing care. The patient with HIV admits to the infectious disease physician that there have been several missed doses of HIV medication in the last month. The infectious disease physician has to weigh their response during the visit — the intonation in their voice, the choice of words — to not only communicate clearly that it is important to not miss doses of HIV medication, but also to create a sense of safety for the patient in sharing information like this in the future.

If the interaction goes poorly, it could erode the sense of trust built up over time, and the patient may be less likely to share their medication adherence shortcomings in the future. If the patient isn't forthright about their medication adherence, it may lead to the infectious disease physician switching HIV medicines to another with greater side effects, even when there was no issue with the original medication.

Because the infectious disease physician is part of ongoing care, and has to weigh these types of factors, that the E/M visit becomes inherently more complex, and the practitioner bills this code (G2211). Even though the infectious disease doctor may not be the focal point for all services, HIV is a single, serious condition, and/or a complex condition, and so as long as the relationship between the infectious disease physician and patient is ongoing, this E/M visit could be billed with the add-on code G2211.

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SOCIAL DETERMINANTS OF HEALTH – AWV

Finalized the addition of the SDOH risk assessment to the AWV as an optional, additional element with an additional payment and no patient coinsurance nor deductible (when provided with the AWV). CMS also finalizing codes and payment for SDOH risk assessments furnished with an evaluation and management or behavioral health visit.

The final SDOH Risk Assessment involves administering a standardized, evidence-based, and culturally and linguistically appropriate SDOH risk assessment tool that considers the patient's educational, developmental, and health literacy level. It would be separately payable with no cost sharing for beneficiaries when performed as part of the AWV.

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SDOH

CMS finalized coverage of **G0136** (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes) and added the code to its permanent list of telehealth services. CMS assigned a national, non-facility payment of $18.66 for the service.

There's a difference between performing the assessment and documenting a patient's SDOH for the purposes of selecting an ICD-10-CM code or determining the level of medical decision-making for an E/M visit

To report G0136, the provider must spend at least five minutes administering a standardized, evidence-based risk assessment tool that includes the SDOH domains of food insecurity, housing insecurity, transportation needs and utility difficulties.

Examples of standardized tools include the "CMS Accountable Health Communities tool, the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment," according to the final rule.

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SDOH CLARIFICATIONS

It's an assessment, not a screening. It is unlikely a practice will administer the assessment to every Medicare patient it treats. The practitioner should administer the assessment when there is "reason to believe there are unmet SDOH needs that are interfering with the practitioner's diagnosis and treatment of a condition or illness," according to CMS.

Follow up is a must. CMS will not require the provider who identifies unmet SDOH to provide follow-up care such care management services. However, they must take some action to address any issues they identify. "We do expect that the practitioner furnishing an SDOH risk assessment would, at a minimum, refer the patient to relevant resources and take into account the results of the assessment in their medical decision making, or diagnosis and treatment plan for the visit," CMS explains in the final rule.

SDOH ICD-10-CM codes aren't required. Don't worry if the information in the assessment doesn't link to a current SDOH diagnosis code. CMS encourages the use of relevant ICD-10-CM codes if one or more codes are available, but they aren't a prerequisite.

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2024 EVALUATION & MANAGEMENT

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SPLIT/SHARED

For CY 2024, CMS are finalizing a revision to our definition of "substantive portion" of a split (or shared) visit to include the revisions to the Current Procedural Terminology (CPT) guidelines, such that for Medicare billing purposes, the "substantive portion" means more than half of the total time spent by the physician or nonphysician practitioner performing the split (or shared) visit, or a substantive part of the medical decision making.

Each chart should clearly show how the care team selected the substantive portion of the visit. In 2021, 2022 and 2023 practices can use time, history, physical exam or medical decision-making (MDM).

The qualified health care professional must be able to report E/M visits independently, even if the physician always performs the substantive portion and reports the service.

Make sure billers/coders report all split or shared services with modifier **FS** (Split [or shared] evaluation and management visit) whether the practice billed the visit under the physician or QHP's name.

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SPLIT/SHARED-QUESTION AMA SYMPOSIUM

Question: *Can the physician simply approve the assessment and plan or do they need to perform or reperform two elements of the MDM to report the service?*

Answer: "I don't think it's a matter of perform and reperform, it's a matter of perform," Hollmann said. "Our feelings as clinicians if you're working together, you're jointly making decisions on things, you're exchanging information and the physician is ultimately determining the course of action."

"I totally agree with that," Levy added. "We have a fixed number of problems that we're addressing at this particular encounter and we have [MDM] with respect to what are we going to do about [the problem]. She continued: "It doesn't make good common sense to repeat things, but it does make sense to review things. And the review of what the nurse practitioner may or may not have already performed is still work and it is being included in the cognitive work of determining the next course of action."

Keep the differences between CPT guidelines and CMS rules in mind as you prepare yourself and your practice for 2024. For example, even though the CPT guidelines allow physician attestations, care teams and coders should remember that Medicare doesn't allow them. According to the final 2024 Medicare physician fee schedule, "when the work is shared, we expect that whoever performs the MDM and subsequently bills the visit would appropriately document the MDM in the medical record to support billing of the visit."

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ADMIT/DISCHARGE SAME DATE

- AMA/CPT will align with CMS in that in order to assign 99234-99236, must have at least 8 hours.

E/M Guidelines Revisions — 99234-99236

Length of Stay	Discharged On	Report Codes
<8 hours	Same calendar date as initial hospital inpatient or observation care service	99221, 99222, 99223
8 or more hours	Same calendar date as initial hospital inpatient or observation care service	99234, 99235, 99236
<8 hours	Different calendar date as initial hospital inpatient or observation care service	99221, 99222, 99223
8 or more hours	Different calendar date as initial hospital inpatient or observation care service	99221, 99222, 99223 and 99238, 99239

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EXAMPLE

- Q: A patient is admitted at 10PM through the ED. I see the patient the next morning at 7AM and then return at 6PM to re-evaluate and ultimately discharge the patient. This is more than 8 hours and on two calendar dates. I cannot report an initial service on the date of admission as the patient was not seen. I cannot report two codes on the date the patient was seen. What may I report?
- A: It seems reasonable to report the appropriate code from 99234-99236 from the point of view of your services. This best reflects what was performed by you. There could be claims edits that would block this as the patient was in over two dates, though unlikely. An alternative would be to report 99221-99223 and use time (and prolonged services, if applicable).

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TIMING CHANGES

Revised threshold times for initial nursing facility (NF) code 99306 and subsequent NF code 99308 to more closely match the rounded times of the RUC survey

This has no effect on value and was prompted by the 2023 MPFS rulemaking comments.

Replaced time ranges in 99202-99205 & 99212-99215 with threshold time

Emphasizing "midpoint" concept does not apply to the codes for which the E/M Guidelines apply

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TIMING CHANGES – NURSING FACILITY

Evaluation and Management
Nursing Facility Services
Initial Nursing Facility Care
New or Established Patient

▲99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using total time on the date of the encounter for code selection, ~~45~~50 minutes must be met or exceeded..

(For services ~~60~~65 minutes or longer, use prolonged services code 99418)

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TIMING CHANGES – OFFICE VISITS

Evaluation and Management
Office or Other Outpatient Services
New Patient

★▲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 total time on the date of the encounter for code selection, 60~~-74 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.

(For services 75 minutes or longer, use prolonged services code 99417)

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TIME CHANGES

CODE	2023 "total time … spent on the date of the encounter"	2024 "total time on the date of the encounter" that "must be met or exceeded"
99202	15-29	15
99203	30-44	30
99204	45-59	45
99205	60-74	60
99212	10-19	10
99213	20-29	20
99214	30-39	30
99215	40-54	40

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PROLONG SERVICES FOR INITIAL (99223) AND SUBSEQUENT (99233)

- CMS will align with AMA/CPT
  - However, CPT coding uses 99418 and CMS uses HCPCS G0316

Table 3. Billing Prolonged Other E/M Visits

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	90 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	65 minutes	Date of visit

Reporting Prolonged Services

Primary Code	Prolonged Services Code	Total Time to Report Initial Unit of Prolonged Services	Total Time to Report Second Unit of Prolonged Services
99223	99418	90	105
99233	99418	65	80

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PSYCHEDELIC DRUG MONITORING (0820T-0822T)

- A new subsection (with new heading), codes, guidelines, and parenthetical notes have been included within the code set to allow reporting of psychedelic drug monitoring services.
- These services focus on the personnel providing the monitoring of the patient that is self-administering a psychedelic medication and the efforts involved in the monitoring.
- Code language includes:
  - Who is providing the service (ie, 1st physician/QHP [0820T]; an added 2nd physician/QHP [0821T]; clinical staff under physician/QHP direction [0822T]);
  - Time taken for the service (ie, one hour);
  - What is done for the service (ie monitoring and intervention as needed);
  - The fact that the monitoring is continuous and in-person.

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PSYCHEDELIC DRUG MONITORING

►Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention) is provided during and following supervised patient self-administration of a psychedelic medication in a therapeutic setting. Psychedelic medications induce distinctive alterations in perception that may place the patient at risk for emotional vulnerability and physiologic instability. The medications' pharmacologic risks may persist for multiple hours, and during this time, the patient may require continuous in-person monitoring and intervention by a physician or other qualified health care professional (QHP) to support the patient's physical, emotional, and psychological safety and to optimize treatment outcomes.◄

►Code 0820T is used to report the total duration of in-person time with the patient by the physician or other QHP providing continuous monitoring, and intervention as needed, during psychedelic medication therapy. Codes 0821T, 0822T are used to report the concurrent in-person participation of a second physician or other QHP (0821T), or the concurrent in-person participation of clinical staff (0822T) based on a patient's complex presentation, that requires additional personnel in the therapy room (eg, a physician or other QHP monitoring patient needs assistance from additional clinical staff due to a crisis by the psychedelic experience that surfaces past psychological trauma).

If necessary, report 0821T, 0822T, as appropriate. It is unlikely that more than two personnel need to be in the room at the same time with the patient (ie, the initial physician or other QHP and one additional physician or other QHP or clinical staff). Psychotherapy (90832, 90833, 90834, 90836, 90837, 90838), psychotherapy for crisis (90839, 90840), neurobehavioral status examination (96116, 96121), adaptive behavior assessments (97151, 97152), adaptive behavior treatment (97153, 97154, 97155, 97156, 97157, 97158), or prolonged clinical staff services (99415, 99416) may not be reported on the same date of service.◄

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EXAMPLE

- Q: A patient is seen in the ED after taking a substance that is determined to be psychedelic. The patient requires continuous attendance. What code is reported?
- **A: This was not a supervised patient self-administration of a psychedelic medication in a therapeutic setting. Report 99282-99285 as appropriate based on MDM.**
- Q: Why not report an E/M which almost certainly is performed and then use prolonged services codes?
- **A: It is incorrect to use E/M when this is a more specific code. Likewise, it would be incorrect to report psychotherapy, psychotherapy for crisis or other codes that are less specific than the Category III code.**

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SURGICAL SERVICES

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NEUROSURGERY

- Electrophysiological Focused Magnetic Stimulation (0858T)
- Peripheral Nerve Transcutaneous Magnetic Stimulation (0766T-0769T)
- Parenthetical Revisions: Gastric Neurostimulator (43882)
- Skull-Mounted Cranial Neurostimulator (61889, 61891, 61892)
- Spinal/Peripheral Neurostimulator Services (63685, 63688, 64590, 64595-64598, 0587T-0590T, 0784T-0789T)

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NEUROSURGERY

Skull-Mounted Cranial Neurostimulator

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Code 61889 — Insertion

- Includes craniectomy or craniotomy when performed
- Direct or inductive coupling
- Connection to depth and/or cortical strip electrode array(s)

2

Code 61891 — Revision or Replacement

- Connection to depth and/or cortical strip electrode array(s)

3

Code 61892 — Removal

- Includes cranioplasty when performed

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NEUROSURGERY

- Coding changes
  - No longer "direct or inductive coupling" wording in code descriptor for implanted pulse generator for spinal or peripheral nerve stimulation
  - New wording
    - 63685 (spinal) and 64590 (peripheral nerve)– "requiring Pocket creation and connection between electrode array and pulse generator/receiver"
    - 63688 (spinal) and 64595 (peripheral nerve) – "with detachable connection to electrode array"

Codes 64596 and 64597

•64596 Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array

+•64597 each additional electrode array (List separately in addition to code for primary procedure)

Nerve	Procedure			
	Insertion/Replacement • Pocket creation • Connection between electrode array and pulse generator/ receiver	Revision/Removal • Detachable connection to electrode array	Percutaneous Insertion/Replacement • With integrated neurostimulator	Revision/Removal • With integrated neurostimulator
Spinal	63685	63688	0784T	0785T
Peripheral, sacral, or gastric	64590	64595		
Peripheral			64596, +64597	64598
Sacral			0786T	0787T
Posterior tibial			0587T	0588T

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NEUROSURGERY

Spinal	
Pre-2024	**2024**
63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	**Removed:** "direct or inductive coupling" **Added:** "requiring pocket creation and connection between electrode array and pulse generator or receiver"
63688 Revision or removal of implanted spinal neurostimulator pulse generator or receiver	**Added:** "with detachable connection to electrode array"

Peripheral, Sacral, or Gastric	
Pre-2024	**2024**
64590 Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	**Removed:** "direct or inductive coupling" **Added:** "sacral" "requiring pocket creation and connection between electrode array and pulse generator or receiver"
64595 Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	**Added:** "sacral" "with detachable connection to electrode array"

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ORTHOPAEDIC SURGERY

- Vertebral Body Tethering (VBT)
  - Four new codes (22836-22838, 0790T)
  - Two revised codes (0656T, 0657T)
  - RUC recommendations
- Metatarsal Arthrodesis for Bunion Correction
  - Six revised codes (28292, 28295-28299)
- Sacroiliac (SI) Joint Arthrodesis
  - One deleted code (0809T)
- Insertion Calcium-Based Implant — Femur
  - One new code (0814T)

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ORTHO SURGERY

- Tethering is used to correct scoliosis without fusion. A tether (cord) is used to compress the convex vertebral growth plates inhibiting their growth, while allowing concave growth plates to grow. Does NOT include arthrodesis/fusion.
- Three new codes added for anterior thoracic VBT- 22836-22838.

►Codes 22836, 22837, 22838 describe anterior thoracic vertebral body tethering, which corrects scoliosis without fusion using a tether (cord) to compress the vertebral growth plates on the convex side of the curve to inhibit their growth, while allowing the growth plates on the concave side of the curve to continue to grow. Codes 22836, 22837 may not be reported with anterior instrumentation codes 22845, 22846, 22847.

For the following codes, when two surgeons work together as primary surgeons performing distinct part(s) of the thoracic vertebral body tethering, each surgeon should report his or her distinct operative work by appending modifier 62 to the procedure code. Modifier 62 may be appended to procedure code(s) 22836, 22837, 22838, as long as both surgeons continue to work together as primary surgeons.

Regions of the spine include cervical, cervicothoracic, thoracic, thoracolumbar, lumbar, lumbosacral, sacral, and coccygeal.◄

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ORTHO SURGERY

#●**0790T** Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed

►(For revision, replacement, or removal of thoracic vertebral body tethering, use 22838)◄

	Location	Number of Vertebral Segments	Anterior VBT Code
Tether placement	Anterior thoracic	Up to 7	22836
Tether placement	Anterior thoracic	8 or more	22837
Tether placement	Anterior lumbar or thoracolumbar	Up to 7	0656T
Tether placement	Anterior lumbar or thoracolumbar	8 or more	0657T
Revision, replacement, or removal	Thoracic		22838
Revision, replacement, or removal	Lumbar or thoracolumbar		0790T

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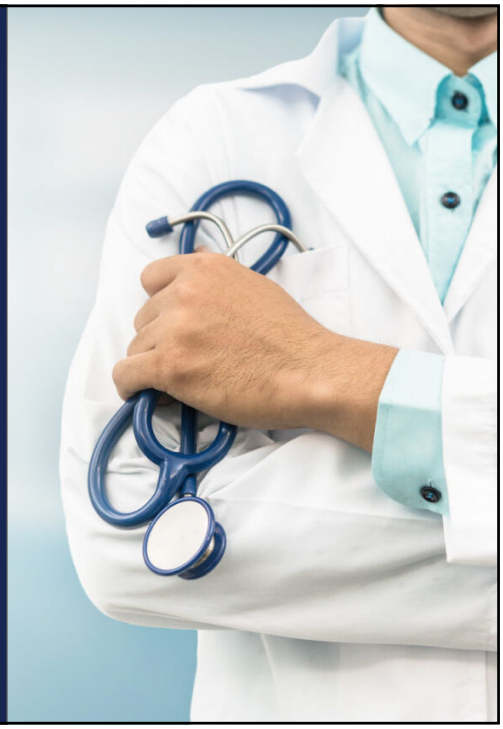
GYNECOLOGY

- Transcervical Radiofrequency (RF) Ablation of Uterine Fibroids (58580)
- Parenthetical Note Revision (58661)
- Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (96547, 96548)
- Pelvic Examination (Practice Expense [PE] Only) (99459)



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GYNECOLOGY

Transcervical Radiofrequency (RF) Ablation of Uterine Fibroids: Rationale for New Code

- Code 0404T (Transcervical uterine fibroid(s) ablation with ultrasound guidance, RF) has been deleted.
- New code 58580 has been established for reporting transcervical RF ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring.
- Code 58580 is placed in the new "Other Procedures" subsection within the Female Genital System section.
- To clarify reporting of these services, an exclusionary parenthetical note has been added, preventing the reporting of code 58580 together with codes 58561, 58674, 76830, 76940, and 76998.
- A cross-reference parenthetical note directs users to report code 58674 for laparoscopic RF ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring.

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GYNECOLOGY

Transcervical Radiofrequency (RF) Ablation of Uterine Fibroids: Rationale for New Code

- Endometrial thermal ablation code (58353) and endometrial cryoablation code (58356) have been moved from the Introduction subsection to the new "Other Procedures" subsection.
- Code 58580 cannot be reported with code 58561 (hysteroscopic removal of leiomyomata), code 58674 (laparoscopic ablation of uterine fibroid[s]), or codes 76830, 76940, and 76998 (ultrasound guidance).
- Monitoring has been added to the descriptor of code 58580 to maintain consistency with other ablation codes. Physicians monitor the status of the RF generator during the ablation procedure.

Parenthetical Revision (58661): Rationale for Revision Code

- To provide clarity in reporting a parenthetical note has been added to clarify that code 58661 is intended as a unilateral procedure.
- If laparoscopic removal of adnexal structures is performed on both ovaries and/or tubes, the modifier 50 may be applied. This identifies that a bilateral procedure was performed during the same session.
- The term "structures" is meant to identify the partial or total removal of tubes and/or ovaries from one side of the anatomical location

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GYNECOLOGY

Pelvic Examination (Practice Expense [PE] Only): Rationale for New Code

- Preventive medicine services codes 99381-99397 were identified for potential gender-based misvaluation. These codes are based on age, not gender, according to the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) Relativity Assessment Workgroup (RAW).
- New Category I add-on code 99459 introduced for reporting pelvic examinations.

Evaluation and Management/Other Evaluation and Management Services

#+●99459 Pelvic examination (List separately in addition to code for primary procedure)

►(Use 99459 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397)◄

99499 Unlisted evaluation and management service

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UROLOGY

- Cystourethroscopy With Urethral Dilation and Urethral Therapeutic Drug Delivery (New Cat I code 52284)
  - Deleted Category III Code (0499T)
- Neurostimulator Services
  - Revised Cat I Codes 64590, 64595
  - New Cat III Codes 0786T-0789T
- Tibial Neurostimulator Services for Bladder Dysfunction
  - New Cat III Codes 0816T, 0817T, 0818T, 0819T
  - Revised Cat III Codes 0587T-0590T
- Remote Patient Multiday Comprehensive Uroflowmetry (New Cat III codes 0811T, 0812T)
- Low-intensity ESWT-Corpus Cavernosum (New Cat III code 0864T)

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UROLOGY

CPT code 52284 has been added to replace a temporary Category 3 code.

This code includes cysto and dilation and is used for males only.

Code 52284-cystourethroscopy with mechanical urethral dilation and therapeutic drug delivery via drug coated balloon catheter for male urethral stricture or stenosis, including fluoroscopy if performed.

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UROLOGY

	Array (Alone)hat's	Generator/Receiver (Separate from array)	Perc placement Integrated (Array with gen/receiver)	Open placement (Integrated leadless device)
Urology	64561 Perc place sacral 64581 Open place sacral 64585 Revision/removal	64590 Place/replace 64595 Revise/remove (Periph/sacral/gastric – attach to [separate] array)	0587T Place tibial 0588T R/R tibial (For bladder dysfunction) 0786T Perc place sacral 0787T R/R sacral	(For bladder dysfunction) 0816T Place subcutaneous 0817T Place subfascial 0818T R/R subcutaneous 0819T R/R subfascial
Others	64553 – Perc cranial 64568 – Open cranial 64555 – Perc peripheral 64575 – Open peripheral Etc.	63685 place/replace spinal 64688 R/R spinal Etc.	64596 Perc place periph 64597 additional array 64598 Revise/remove periph	
Programming	N/A	95971 – Simple 95972 – Complex (Note: Can be performed same day)	0589T/0590T: Simple/complex analysis or program integrated for leadless neurostimulator system for bladder dysfunction, post-tibial nerve, different day 0788T/0789T: For 0786T/0787T 97951/95972: For 64596, etc.	

New grid added for pulse generator/neurostimulator plac ement and/or programming:

Note codes 0816T-0819T, open neurostimulator services for the posterior tibial nerve, are assigned only for bladder DYSFUNCTION and not for other symptoms such as pain, etc.

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INTERVENTIONAL RADIOLOGY

Dorsal Sacroiliac Joint Arthrodesis Guidelines Revision (27278)

Musculoskeletal System/Pelvis and Hip Joint/Arthrodesis

►Code 27279 describes percutaneous arthrodesis of the sacroiliac joint using a minimally invasive technique to place an internal fixation device(s) that passes through the ilium, across the sacroiliac joint and into the sacrum, thus transfixing the sacroiliac joint. Report ~~0775T~~27278 for the percutaneous placement of an intra-articular stabilization device into the sacroiliac joint using a minimally invasive technique that does not transfix the sacroiliac joint. ~~For percutaneous arthrodesis of the sacroiliac joint utilizing both a transfixation device and intra-articular implant(s), use 27299 0809T.~~◄

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INTERVENTIONAL CARDIOLOGY

- Percutaneous Coronary Interventions (92972)
- Venography Services (93584-93588)
- Transcatheter Pulmonary Artery Denervation (0793T)
- Dual-Chamber Leadless Pacemaker (0795T-0804T) & Parenthetical Revisions (0795T-0800T)
- Superior Vena Cava (SVC)-Inferior Vena Cava (IVC) (SVC-IVC) Prosthetic Valve Insertion (0805T, 0806T)
- Wireless Cardiac Stimulation System for Left Ventricular (LV) Pacing (0517T-0520T, 0861T-0863T)

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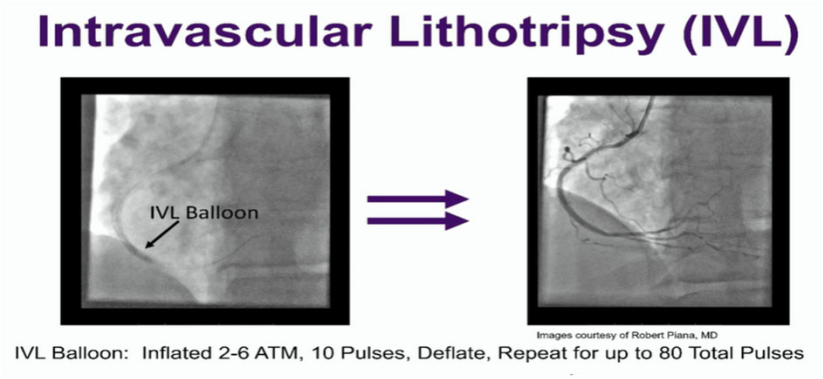
INTERVENTIONAL CARDIOLOGY

- Add-On code 92972 changed from Category 3 to a CPT code
- Described as Intravascular Lithotripsy (IVL)
- Used with other coronary interventional procedures, to treat heavily calcified coronary arteries that will not dilate with traditional techniques (alternative to atherectomy)



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INTERVENTIONAL CARDIOLOGY

- Currently there is not a good way to report venography done with congenital cardiac catheter procedures. New add on codes created for this issue.
- Codes 93584-93588 are used to report treatment of congenital heart defects via venography.
- Radiological supervision and interpretation (S & I) included.
- Use in addition to procedures performed during heart catheterization for congenital heart defects.

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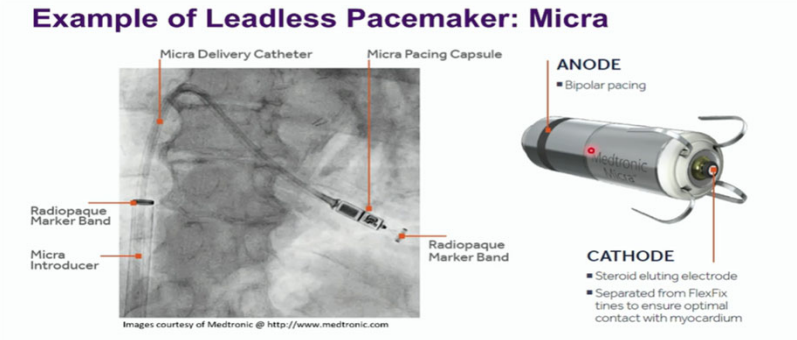
INTERVENTIONAL CARDIOLOGY

- New category 3 codes for dual-chamber leadless pacemakers with grids and guideline revisions.
- Codes 0795T-0804T allow reporting of transcatheter permanent dual-chamber leadless pacemaker procedures.



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INTERVENTIONAL CARDIOLOGY

Procedure	System	
	Pacemaker	Implantable Defibrillator
Insertion, replacement, or removal and replacement of permanent single-chamber leadless ventricular pacemaker	33274	N/A
Insertion permanent single-chamber leadless pacemaker, right atrial	0823T	N/A
Insertion permanent dual-chamber leadless pacemaker, right atrial and right ventricular components	0795T	N/A
Insertion permanent dual-chamber leadless pacemaker, right atrial component	0796T	N/A
Insertion permanent dual-chamber leadless pacemaker, right ventricular component (when part of a dual-chamber leadless pacemaker system)	0797T	N/A

Procedure	System	
	Pacemaker	Implantable Defibrillator
Removal and replacement permanent dual-chamber leadless pacemaker, right atrial and right ventricular components	0801T	N/A
Removal and replacement permanent dual-chamber leadless pacemaker, right atrial component	0802T	N/A
Removal and replacement permanent dual-chamber leadless pacemaker, right ventricular component (when part of a dual-chamber leadless pacemaker system)	0803T	N/A
Removal of permanent single-chamber leadless ventricular pacemaker	33275	N/A

Procedure	System	
	Pacemaker	Implantable Defibrillator
Removal permanent dual-chamber leadless pacemaker, right atrial and right ventricular components	0798T	N/A
Removal permanent dual-chamber leadless pacemaker, right atrial component	0799T	N/A
Removal permanent dual-chamber leadless pacemaker, right ventricular component (when part of a dual-chamber leadless pacemaker system)	0800T	N/A

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CARDIOLOGY

- New codes 33276-33281, 33287, 33288, 93150-93153
- Codes 33276-33288 are used to report insertion, removal, repositioning, and replacement of phrenic nerve stimulator and/or components
- Insertion-33276-33277
- Removal-33278-33280
- Repositioning-33281
- Replacement-33287-33288-including a pulse generator and one stimulation lead

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CARDIOLOGY

Codes 93150-93153 identify phrenic nerve stimulation system.

Therapy activation-93150.

Interrogation/Programming-93151-93152.

Subsequent Interrogation-93153.

These codes are reported when separate programming or interrogation services are required (i.e. evaluate device for optimization).

They may not be reported for phrenic nerve stimulation services performed on the same day.

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ADDITIONAL SECTION UPDATES

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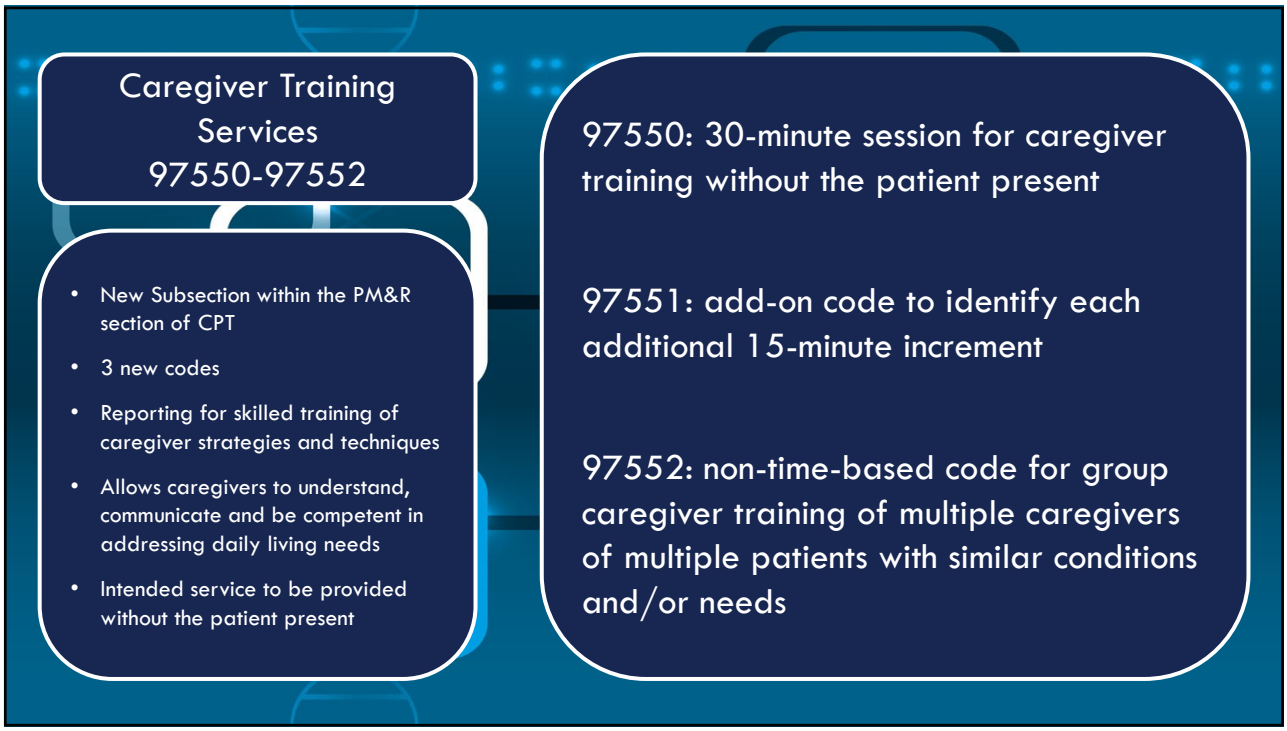

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NEW CODE FOR POST-OPERATIVE LOW-LEVEL LASER THERAPY

CPT 97037

- Requires constant attendance
- Child code of CPT 97032 (electrical stimulation)
- Treatment is entirely non-thermal and non-ablative
- Designed for post-operative pain reduction

** Note: no specialties surveyed this code or sent recommendations to the RUC, therefore this code has been placed on the New Technology list and a review will be conducted once data is available**

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PHYSICAL THERAPY EVALUATIONS: 97161 – 97164

4 key components:

History – includes documentation of personal factors and/or comorbidities that impact the plan of care.

Examination: examination of body systems utilizing standardized tests and measures that address body structures/functions, activity limitations and/or participation restrictions.

Clinical Decision Making: describing clinical presentation and characteristics. Low, moderate or high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.

Development of Plan of Care.

Review the CPT section related to these codes for a detailed description of what is defined in a low, moderate or high complexity evaluation

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PHYSICAL THERAPY EVALUATIONS (CONT.)

Definitions:

- Body Regions: head, neck, back, lower and upper extremities, trunk.
- Body Systems: musculoskeletal, cardiovascular, pulmonary, integumentary:
  - Further guidance on body system review is outlined in CPT.
- Body Structures: structural or anatomical parts of the body, such as organs, limbs, their components as classified according to body system.
- Personal Factors: includes sex, age, coping styles, social background, education, professional, past and current experiences, overall behavior patterns, character, and other factors that influence how the disability is experienced by the individual. **personal factors that do not impact the plan of care are not to be considered when selecting the level of service**

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OCCUPATIONAL THERAPY EVALUATIONS: 97165 - 97168

4 key components:

- Occupational profile and client history – medical and therapy history, which includes review of medical and/or therapy records related to the presenting problem.
- Assessment of occupational performance: identify performance deficits related to physical, cognitive or psychosocial skills that result in activity limitations and/or participation restrictions.
- Clinical Decision Making: analysis of occupational profile, analysis of data from assessments and consideration of treatment options. Consider any comorbidities that affect performance and any modifications of tasks or assistance necessary to enable patient to complete the evaluation.
- Development of Plan of Care.

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OCCUPATIONAL THERAPY EVALUATIONS (CONT.)

Definitions:

Performance Deficits: refers to the inability to complete activities due to lack of skills in one or more the categories below:

- Physical Skills: impairment of body structure or body function.
- Cognitive Skills: ability to attend, perceive, think, understand, problem-solve, mentally sequence, learn and remember resulting in the ability to organize occupational performance in a timely and safe manner.
- Psychosocial Skills: interpersonal interactions, habits, routines and behaviors, active use of coping strategies, and/or environment adaptations to develop skills necessary to successfully and appropriately participate in everyday tasks and social situations.

**additional detail provided in CPT

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ATHLETIC TRAINING EVALUATIONS: 97169 - 97172

4 key components:

- History and physical activity profile – includes documentation of comorbidities that impact the plan of care.
- Examination: examination of affected body area and other related systems to include body structures, physical activity and/or participation deficiencies.
- Clinical Decision Making: describing clinical presentation and characteristics. Low, moderate or high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.
- Development of Plan of Care.

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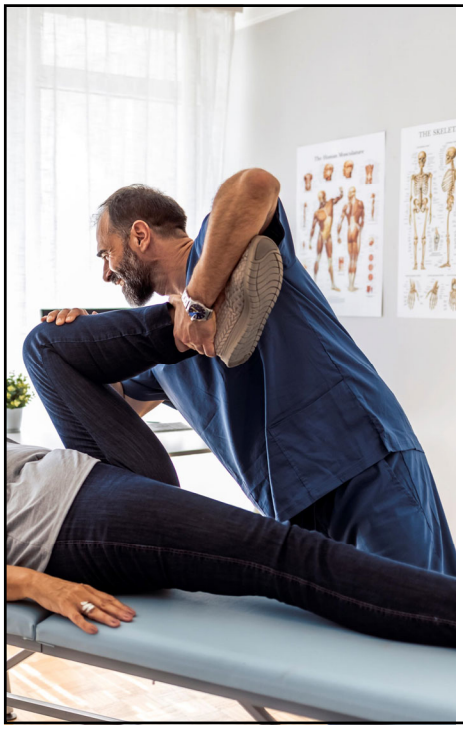

ATHLETIC TRAINING EVALUATIONS (CONT.)

- **Definitions:**
  - Body Systems: head, neck, back, lower and upper extremities, trunk.
  - Body Systems: musculoskeletal, cardiovascular, pulmonary, integumentary:
    - Further guidance on body system review is outlined in CPT.

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SR0

CODE RANGES

Physical Therapy:

- 97161 – low complexity, typically 20 minutes
- 97162 – moderate complexity, typically 30 minutes
- 97163 – high complexity, typically 45 minutes
- 97164 – re-evaluation, typically 20 minutes

Occupational Therapy:

- 97165 – low complexity, typically 30 minutes
- 97166 – moderate complexity, typically 45 minutes
- 97167 – high complexity, typically 60 minutes
- 97168 – re-evaluation, typically 30 minutes

Athletic Training Evaluations:

97169 – low complexity, typically 15 minutes

97170 – moderate complexity, typically 30 minutes

97171 – high complexity, typically 45 minutes

97172 – re-evaluation, typically 20 minutes

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ADDITIONAL GUIDANCE

Modalities:

- Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.
  - Supervised – does not require direct (one-on-one) patient contact
    - Constant Attendance – requires direct (one-on-one) patient contact

Therapeutic Procedures:

A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.

Tests & Measurements:

Requires direct one-on-one patient contact.

Orthotic Management & Training and Prosthetic Training

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Slide 71

SR0 Can we please change the font for athletic training
Susan Rohde, 2023-11-27T21:15:41.762

OPHTHALMOLOGY

New code for Suprachoroidal Injection – 67516:

- This is a category III code, 0465T that has been converted to a category I code.
- Use this to report the injection of a drug into the suprachoroidal space between the sclera and choroid.
- Note that this code is identified as a 'separate procedure'.

Subretinal Drug-delivery injection – Category III code 0810T:

- Describes the delivery of a pharmacologic agent into the subretinal space in the posterior segment of the eye.
- Typically performed with a vitrectomy.

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OTOLARYNGOLOGY

Posterior Nasal Nerve Ablation – new codes 31242 and 31243:

Performed to treat chronic rhinitis or 'runny nose'.

31242 is destruction by radiofrequency ablation of posterior nasal nerve.

31243 is destruction by cryoablation of posterior nasal nerve.

Auditory Osseointegrated Device Services – new codes 92622 and 92623:

Bone anchored hearing aid where it integrates with the patient's skull.

Differs from a cochlear implant in that hearing loss is addressed at the level of the middle ear rather than the cochlea.

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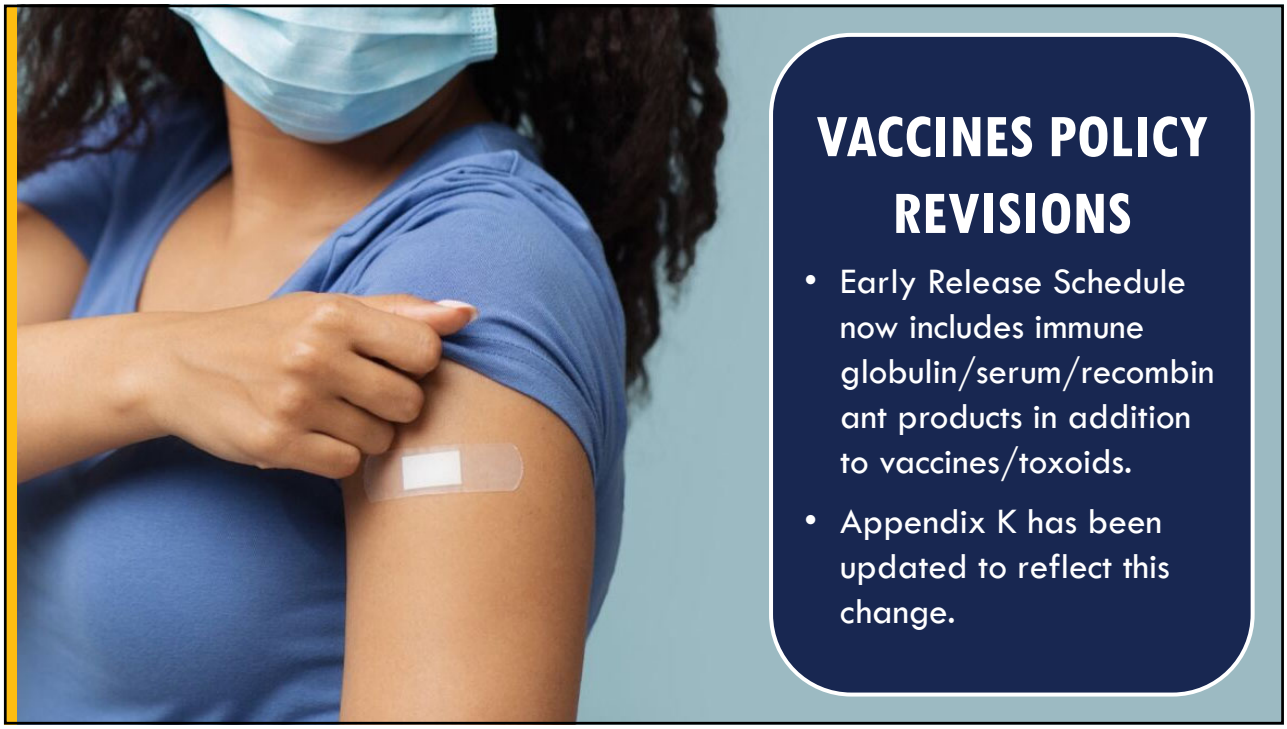

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VACCINE VS. IMMUNE GLOBULIN

Vaccine	Immune globulin
• Prevention	• Prevention/Treatment
• Derived from live/inactive bacteria and viruses	• Derived from existing antibodies
• Stimulates immune system to produce antibodies	• Does not stimulate immune system to produce antibodies
• Provides active immunity	• Provides passive immunity

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COVID-19 IMMUNIZATION CHANGES

FDA has requested that all manufacturers in the US update their vaccine composition to a monovalent COVID-19 vaccine with XBB-lineage of the Omicron variant.

Because of this request, as of November 1, 2023, only monovalent vaccines with XBB.1.5 Omicron subvariant will be used in the US and reported with a single administration code:

- Addition of 3 Pfizer (91318, 91319, 91320) and 2 Moderna (91321, 91322) product codes.
- Addition of 1 administration code – 90480.
- Revision of the parenthetical note for code 91304 (Novavax) that instructs users to report 90480 for administration.
- Deletion of 64 category I product and administration codes.

The AMA website lists the most current CPT codes to report COVID-19 products and administration: https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-vaccine-and-immunization-codes

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OTHER NEW VACCINE CODES

- RSV (pediatric, seasonal) Ig: 90380 and 90381. Administration codes 96380 and 96381:
  - Released on June 30, 2023 and effective July 17, 2023.
- RSV Adjuvanted Vaccine: 90679:
  - Released on May 5, 2023 and effective May 3, 2023.
- RSV mRNA Vaccine: 90683:
  - Released on June 30, 2023 and effective January 1, 2024.
- Chikungunya Virus Vaccine: 90589:
  - Viral disease spread through the bite of an infected mosquito.
  - Released June 30, 2023 and effective January 1, 2024.

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FINAL THOUGHTS

- Review CPT for detailed code descriptions and follow guidance outlined in the parenthetical and instructional notes.
- Review the code changes in their entirety and determine which changes impact your organization.
- Schedule meetings with affected clinical areas to inform them of the changes and/or determine any new services that will be performed.
- Update the chargemaster, preference lists, order entry systems and charging mechanisms to accommodate for all code changes.
- Provide education and training to providers and clinicians.

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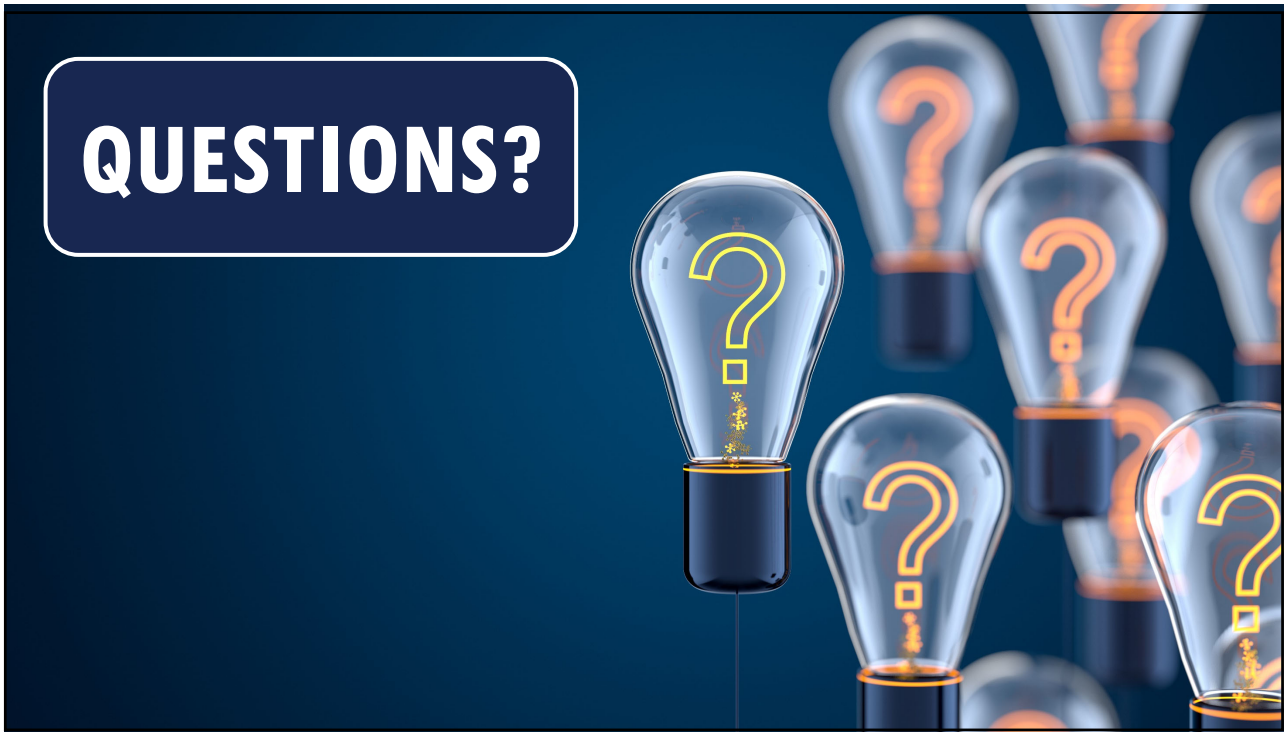

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THANK YOU!

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