Evaluation and Management Services

A new subcategory of service was added this year for *chronic care management* to describe services for a defined set of patients, "… when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring a care plan." Services are billed per month, using CPT code 99490:

> *Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.*

CMS announced a new chronic care management program starting in January of 2015, which will allow practices to bill for providing chronic care management to patients with two or more chronic conditions. This new code can be a good source of additional income for many practices, but the program involves some very specific requirements in order for you to get paid.

So before you make the consideration on billing for Chronic Care Management (CCM) – there are five requirements you must meet:

1. Use of a certified Electronic Health Record (EHR) for specified purposes
2. Maintain an Electronic Care Plan
3. Ensure beneficiaries have access to care 24/7 for acute/urgent issues
4. Facilitate transitions of care for the patient from one site of service to another
5. Coordinate care among different providers as part of the care plan

Now I'll address some of the questions I've been asked about CCM in the sections outlined below.

Do I have to have an Electronic Medical Record?

Yes – you are not required to be a meaningful user of certified EHR technology, but you are required to use what CMS calls a "CCM certified technology user." You'd want to contact your EHR company to ensure you are using - CCM certified technology.

Do I have to be a recognized patient-centered medical home (PCMH) to provide CCM?

No – but, the transformation to PCMH would better position you to successfully provide CCM services.

What types of patients are eligible for chronic care management?

Patients with two or more chronic conditions expected to last at least 12 months, or until death, that place the individual at significant risk of death, acute exacerbation/decompensation, or functional decline.

> Here's the chronic condition website: www.ccwdata.org

Do I need permission from the patient in order to bill CCM services?

Yes, a signed agreement with the patient will allow you to bill for these services. It must detail:

- The nature of CCM
- How the patient can access CCM services
- That only one provider at a time can furnish CCM
- That the patient's health information will be shared with other providers for care coordination
- The patient may discontinue receiving CCM at any time
- The patient will have to pay deductibles and co-insurances associated with CCM.

Will both traditional Medicare and managed care Medicare cover these services?

Yes, however, they aren't considered preventive, so all applicable co-pays, deductibles and co-insurance will apply.

How many providers can bill for the chronic care management code in a 30-day period?

Only one - This is why you need the patient's signed agreement in writing prior to providing these services.

Who can bill for this CCM service?

Physicians, NPs, Pas, clinical nurse specialists, and CNM can bill for CCM services.

What do I have to document in order to bill for chronic care management?

You need to provide (and document) 20 minutes or more of chronic care management (non-face-to-face) and/or face-to-face services per patient per 30 day billing period.

Common CCM items included in a care plan:

- Problem list
- Symptom management
- Community/social services
- Plan of care coordination with other providers
- Medication management
- Responsible individual for each intervention
- Requirements for periodic review/revision

What are some non-face-to-face care management services I can provide?

- Medication reconciliation and overseeing the beneficiary's self management
- Ensuring receipt of all recommended preventive services
- Monitoring the beneficiary's condition (physical, mental, and social)
- Providing education and addressing questions from the patient, family, guardian, and/or caregiver

- Identify and arrange for needed community recourses
- Communicating with home health agencies and other community service providers utilized by the beneficiary

In the CCM record I'd suggest this:

1. Date and time spent providing the services (start and stop times)
2. Name and credential of clinical staff providing the services
3. Brief description of what was done

Among the requirements of the chronic care management code is something referred to as transitional management, what's that?

You must do the following:

- Follow-up with the patient after a visit to the Emergency Department
- Provide Transitional Care Management (even though as you'll see below - you can't code separately for those TCM services
- Coordinate referrals to other physicians and necessary service providers
- Share patient information electronically, as appropriate – hence the need for CCM technology discussed above.

What is the CPT code for chronic care management and what does it pay?

CPT code 99490 for Medicare and the allowable is approximately $40.40 per patient, per month.

What can't I bill with the CCM codes in a month-long period?

There are four things we can't bill for when billing CCM:

1. Transitional care management (99495 and 99496)
2. Home health oversight (G0181)
3. Hospice oversight (G0182)
4. ESRD services (90951-90970)

As you review the CCM services in CPT and with CMS, you'll see that CMS is not reimbursing for the Complex chronic care management services: 99487-99489.

For more information on CCM coding – I've added an article to my website that goes into more detail:

Just visit www.thecodingeducator.com and under "useful links" you'll find an article on 2015 CCM codes.

Two additional Evaluation and Management codes for 2015 that CMS is not paying for are:

99497	Advanced care planning for advanced directives; first 30 minutes
+99498	each additional 30 minutes

Anesthesia

Three anesthesia codes are deleted in 2015 - 00452, 00622, and 00634. There are no other changes in this section to discuss within the context of this article.

Those three deleted codes represented:

00452	Radical surgery on the clavicle and scapula
00622	Thoracolumbuar sympathectomy
00634	Chemonucleolysis in the lumbar region of the spine

Integumentary

In the Mohs surgery section a cross-reference note has been added instructing coders to use 88311-88314 and 88342 if additional stains or immunostains are required in addition to the standard Mohs codes 17311-17315.

Musculoskeletal

Several arthrocentesis codes are revised, and others added, to allow us to bill procedures with or without guidance.

Look at 20600 – 20611 and you'll find the old codes that we use to use for arthrocentesis and some new codes for the same procedures with ultrasound guidance. Those new codes are billed alone and will include the ultrasound service code within the single code.

For example:

20610	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa
20611	Arthrocentesis, aspiration and/or injection; major joint or bursa with ultrasound guidance, *with permanent recording and report*

Ultrasound images will have to be captured and maintained as part of the surgical record. It is not enough to state ultrasound guidance was used.

New codes 21811–21813 describe unilateral, open treatment of rib fracture(s) with internal fixation.

Category III code 0092T for a second level cervical disc arthroplasty has been deleted. If you do these (artificial disc) procedures – please look at the revised code 22856 and its add-on code +22858 for further clarification.

Another Category III code that has been deleted and changed to a Category I code is 0334T. This procedure is for Arthrodesis, sacroiliac joint, *percutaneous* or minimally invasive with placement of transfixing device. That new code 27279 is located atop of revised code 27280 for an *open* arthrodesis of the sacroiliac joint.

Codes 22510–22515 replace 22520–22525 (percutaneous vertebroplasty and percutaneous vertebral augmentation). The new codes describe the same procedures, but include bone biopsy, when done, plus all the imaging guidance necessary to perform the procedure.

Old Code	Description	New Code
22520	Perc vertebroplasty, 1 vertebral body, unilateral or bilateral injection; thoracic	22510
22521	Perc vertebroplasty, 1 vertebral body, unilateral or bilateral injection; lumbar	22511
22522	+ each additional thoracic or lumbar vert body	22512
22523	Perc vertebroplasty, 1 vertebral body, unilateral or bilateral cannulation; thoracic	22513
22524	Perc vertebroplasty, 1 vertebral body, unilateral or bilateral cannulation; lumbar	22514
22525	+ each additional thoracic or lumbar vert body	22515

Finally, make sure that you take a look at the deleted codes 29020 and 29025 – these were for a turnbuckle jacket and are no longer available in CPT for 2015.

Respiratory

Because of the new ECMO / ECLS service codes (33946-33989) – an exclusionary parenthetical note now follows CPT code 32100 (Thoracotomy; with exploration). Now, you are not able to use 32100 Thoracotomy code with the following ECMO / ECLS codes that we'll discuss shortly: (19260, 19271, 19272, 32503, 32504, 33955, 33956, 33957, 33963, 33964)

Cardiovascular

Codes 33215–33264 are revised to replace references to "pacing cardioverter-defibrillator" with "implantable defibrillator," while new codes 33270–33273 describe insertion and repositioning of "permanent subcutaneous implantable defibrillator" components.

The guidelines for the Pacemaker or Implantable Defibrillator subsection are substantially revised, with nearly two full pages of added text.

The bulk of these changes are cosmetic, however, the guideline section should be reviewed for further clarification of what an implantable defibrillator system includes.

Current state-of-the-art electronics and batteries now have enabled an implantable device to deliver enough energy to defibrillate the heart *without the need for a lead inside the chambers of the heart* or

on its surface, with similar efficacy and safety as a conventional ICD. The new technology is referred to as an S-ICD.

The new *subcutaneous implantable defibrillator* (S-ICD) codes are sequenced as Category I codes: 33270-33273. There you will find codes for the insertion, replacement, removal and repositioning of these new S-ICD systems. Please check with your physician to see if they are using subcutaneous implantable defibrillators as the new codes have replaced the deleted Category III codes: 0319T – 0328T.

There are two new mitral valve surgery codes that you might want to look at this year. They replace Category III codes 0343T and 0344T:

33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed, initial prosthesis
+33419	additional prosthesis (es) during same session

As a result of the new code 33418, several parenthetical notes have been added/changed following codes 33367-33369. Those three add-on codes for cardiopulmonary bypass support can now be used in addition to the new code - 33418.

A new subsection, guidelines, and codes 33946–33989 are added for extracorporeal membrane oxygenation and extracorporeal life support services – ECMO and ECLS (cardiac and/or respiratory support to the heart and /or lungs). These systems provide cardiac and respiratory support for patients whose heart and lungs are diseased or damaged beyond function.

With the establishment of these new ECMO and ECLS codes, several parenthetical notes through this section have been revised to include inclusion and/or exclusion of various services.

There is also a code that has been added to indicate that "planning" time of 90 minutes has been provided by a physician prior to a fenestrated visceral aortic endograft procedure. If this is a procedure your doctor provides, you'd want to look at CPT code 34839.

On the transcatheter placement of intravascular stent codes (37215-37218) have been revised to clarify that they are *open or percutaneous* procedures. The new code, (33218) has been created to report transcatheter placement of intravascular stent(s) in the intrathoracic common carotid artery or innominate artery by percutaneous antegrade approach.

Digestive System

Several codes in the Esophagoscopy and Esophagogastroduodenoscopy subsections (43180–43259) saw some new codes, some minor descriptor revisions and several parenthetical changes.

For example, a new code 43180 has been created for a rigid transoral esophagoscopy performed with diverticulectomy of the hypopharynx or cervical esophagus.

The descriptor for 43194 *Esophagoscopy, rigid, transoral; with removal of foreign body(s)* now specifies plural "body(s)" (rather than singular "body") to clarify that this code may be used for removal of one or more foreign bodies.

More significantly, CPT® 2015 included dozens of new parenthetical notes in these sections to help *resolve bundling issues and to explain proper code application.*

The new **Endoscopy, Stomal** subsection includes guidelines encompassing new, revised, and existing codes 44380-44408, which include proctosigmoidoscopy, sigmoidoscopy, colonoscopy, and colonoscopy through stoma. The new guidelines specify, "When bleeding occurs as a result of an endoscopic procedure, control of bleeding is not reported separately during the same operative session."

Colonoscopy Changes

Within the Endoscopy section there are several minor changes within code range: 45330-45398. I've outlined the significant changes below:

Definition of Colonoscopy

The definition of a colonoscopy examination is now specifically described in CPT as the examination of the entire colon, from the rectum to the cecum or colon-small intestine anastomosis, and may include examination of the terminal ileum or small intestine proximal to an anastomosis.

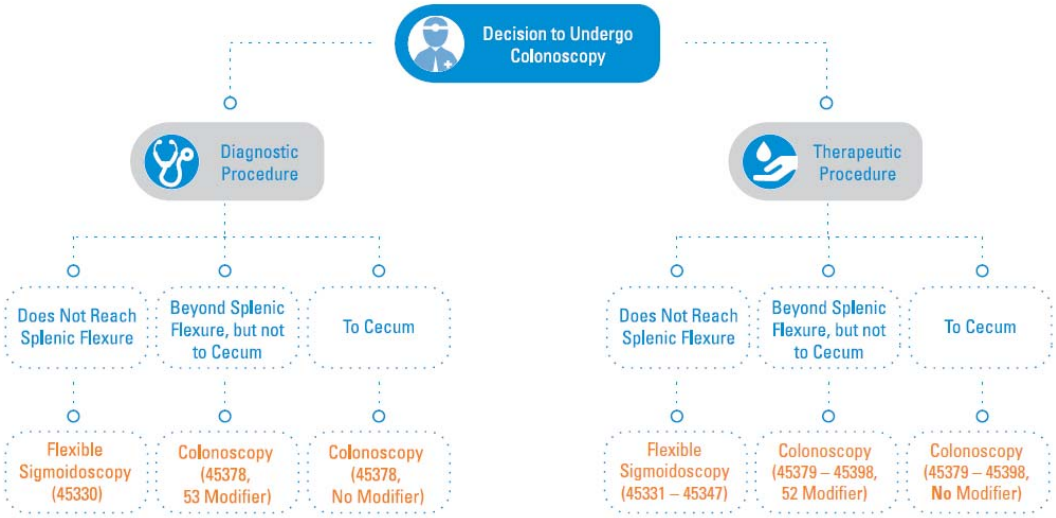
- When performing a diagnostic or screening procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report 45378 (colonoscopy) or 44388 (colonoscopy through stoma) with modifier 53 and provide appropriate documentation.
- If a therapeutic examination colonoscopy is performed and does not reach the cecum or colon-small intestine anastomosis, report the appropriate therapeutic colonoscopy code with modifier 52 and provide appropriate documentation.

New codes for the colonoscopy family include endoscopic mucosal resection (EMR), band ligation and decompression for pathologic distention. Revised codes address appropriate reporting of ablation and stent placement.

Control of Bleeding

Previous code descriptors for control of bleeding codes included a list of examples such as injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler and plasma coagulator. The new descriptor for control of bleeding replaces all examples with "any method" throughout all GI endoscopy families. Do not report submucosal injection if the injection was part of the control of bleeding procedure. New language in the section guidelines clarifies that when bleeding occurs as the result of an endoscopic procedure, control of bleeding is not separately reported during the same operative session.

This is the Colonoscopy Decision Tree:



For more information on GI changes – I've added an article to my website that goes into more detail:

Just visit www.thecodingeducator.com and under "useful links" you'll find an article on 2015 GI codes.

Editorial Changes in This Section

There was a significant editorial change within this section:

"with or without collection of specimen(s)"

Replaced by:

"including collection of specimen(s) by brushing or washing when performed"

Ablation: all codes now include pre/post dilation, guidewire passage, if performed

Stent: all codes now include pre-dilation, post-dilation, and guide wire passage, if performed.

Colorectal Screening

G0464 Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)

CMS covers once every three years.

Medicare G codes for 2015

If the code has not changed from 2014 to 2015

1. Physicians report the CPT code
2. CMS fees based on 2014 values

If the code has changed from 2014 to 2015

1. Physicians report the G code
2. CMS fees based on the 2014 values

If the code is new for 2015

1. Physicians report the CPT code
2. Not valued by CMS

2014 CPT	2015 HCPCS	Description
44383	G6018	Ileoscopy, through stoma, with transendoscopic stent placement
44393	G6019	Colonoscopy through stoma; with ablation of tumor(s) or other lesions
44397	G6020	Colonoscopy through stoma; with transendoscopic stent placement
44799	G6021	Unlisted procedure, intestine
45339	G6022	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s) or other lesion(s)
45345	G6023	Sigmoidoscopy, flexible; with transendoscopic stent placement
45383	G6024	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s)
45387	G6025	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement
0226T	G6026	Anoscopy, high resolution (HRA)….with brushing or washing when performed
0227T	G6027	Anoscopy, high resolution (HRA)….with biopsy(ies)

The last changes was a new Category III code (0355T) for an intraluminal GI tract imaging service of the colon, with interpretation and report (e.g, capsule endoscopy)

Urinary System

Two new codes in the Vesical Neck and Prostate subsection describe *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant* (52441) and each additional implant (+52442).

Maternity Section

The maternity care and delivery guidelines have been revised to show that pregnancy confirmation during a problem EM visit or preventive visit is not considered a part of the antepartum care and should be reported using the appropriate EM code.

Nervous System

Four new codes (62302-62305) describe myelography (radiographic exam with contrast to detect pathology of the spinal cord) by spinal region (e.g., cervical, thoracic).

New codes also describe unilateral (64486-64487) and bilateral (64488-64489) transversus abdominis plane (TAP) block. Also known as abdominal plane block or rectus sheath block, a TAP block is a peripheral nerve block designed to anesthetize the nerves supplying the anterior abdominal wall.

Ophthalmology

New and revised codes in this section describe various procedures pertaining to aqueous shunt, with or without graft:

66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft
66180	with graft

A high percentage of shunts were done with sclera patch graft (67255) so a code was added to reflect the typical work done for this procedure.

66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft
66185	with graft

(Do not report 66185 with 67255)

If you were using Category III code 0181T – it's been replaced with a new Category I code 92145:

92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report.

A new Category III code was developed this year for Ophthalmologists for the insertion of drug-eluting implant into lacrimal canaliculus (each) – CPT code 0356T

Audiology

Codes 69400 and 69405 have been deleted. CPT® 2015 instructs the coder to use 69799 in place of 69400 and 69405.

Transnasal eustachian tube inflation without catheterization (69401) has been deleted and is now inclusive of outpatient E/M codes 99201-99205 and 99211-99215.

Radiology Changes

Vertebroplasty

Codes 72291 and 72292 for vertebroplasty services have been deleted. Radiological supervision and interpretation for *percutaneous vertebroplasty* is now an inclusive component of 22510, 22511, 22513, 22514, and 22515, as well as 0200T and 0201T (percutaneous sacral augmentation (sacroplasty)).

Breast Ultrasound

76645 has been deleted. Two new codes have been created for a breast ultrasound:

76641	Ultrasound, breast, unilateral…
76642	limited

Breast Tomosynthesis

New codes 77061-77063 describe unilateral, bilateral, and screening digital breast tomosynthesis (3-D mammography). Tomosynthesis provides a clearer, more accurate view compared to digital mammography alone.

CMS has issued a new add-on G code (G2079) to report breast tomosynthesis (3D mammography) to be used with the existing digital diagnostic mammography (2D) G codes seen below:

G0204	Diagnostic mammography, producing direct digital image, bilateral, all views
G0206	Diagnostic mammography, producing direct digital image, unilateral, all views

In 2015 CMS will continue to use G-codes for digital mammography using the 2014 RVU for 2015. They have agreed to look at the RVUs for these three G codes in 2016:

77055 – Mammography, unilateral (G0206)
77056 – Mammography, bilateral (G0204)
77057 – Screening mammography, bilateral (G0202)

DXA Scan

Code 77082 is deleted and replaced by two codes describing dual-energy X-ray absorptiometry (DXA) bone density study:

77085 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment

Reported when the bone density study is performed with vertebral fracture assessment

77086 Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA),

Reported when vertebral assessment alone is performed via DXA

Medical Radiation Planning

Teletherapy isodose planning codes are simplified with the introduction of 77306 (simple) and 77307 (complex).

Brachytherapy isodose planning codes are also replaced: The new codes are 77316 (simple), 77317 (intermediate), and 77318 (complex).

Radiation Treatment Delivery

Codes for radiation treatment delivery have been made easier and now include the term "*per day*" for superficial and/or ortho voltage (77401), as well as codes for simple (77402), intermediate (77407), and complex (77412) delivery. All the treatment delivery codes are reported once per treatment session.

Two new codes were created (77385, simple and 77386, complex) to report intensity *modulated radiation treatment delivery* (IMRT). These codes include guidance and tracking, when performed. IMRT allows the radiation oncologist to adjust the intensity of radiation beams across the treatment area, allowing higher radiation doses than traditional radiation therapy methods, while minimizing exposure to healthy tissues.

Laboratory Changes

The AMA made several changes in the Pathology and Laboratory 80000 series code section of the CPT. There were **107** new codes added, **47** deleted codes and **32** revised codes.

There is a large revision of the drug screening codes for 2015 with five (5) new codes and the deletion of the current drug screening codes. There are fifty-eight (58) new drug codes for quantitative drug testing.

The **old system** of drug testing focused on qualitative (identified the family of the drug: yes/no) and quantitative (identified specific analytes with a single code (how much of the drug)

The new system focuses on "presumptive" versus "definitive" testing. This takes into account the advances in medicine, number of materials tested, and the growth in the types of medical practices that have to deal with a lot of drug testing.

So the drug testing section of the code book has been revised to update the drug procedures but the same three subsections were retained. Detailed instructions are provided under the "Drug Assay"

section of the code book. Something else that's interesting is the addition of a definition and acronym conversion listing table to assist us in drug terminology. The AMA also provided a list of drug classes, Class A and Class B, as well as a definitive drug testing table to assist the coder in assigning the appropriate code(s) for a given drug(s) for that given methodology.

The three subsections associated with drug procedures are:

- Drug Assay,
- Therapeutic Drug Assay (TDA), and
- Chemistry

In the "Drug Assay" section, is where you'll find the two following subsections that are now the major categories for testing:

- Presumptive Drug Class (80300-80304)
- Definitive Drug Class Codes (80320-80377)

Presumptive drug class procedures are used to identify possible use or non-use of a drug or drug class. A presumptive test maybe followed by a definitive test to specifically identify drugs or metabolites.

Definitive drug class procedures are qualitative or quantitative test to identify possible use or non-use of a drug. These tests identify specific drugs. Tables are provided to assist with proper code selection.

Presumptive Drug Class

A key point for **Presumptive Drug** testing is that the reported value may be qualitative, semi-quantitative or quantitative depending on the purpose of the testing. The list of drug classes and the methodology used are considered when coding presumptive procedures.

AMA provides a complete list of drugs categories as "Drug Class A" or "Drug Class B" in the code book, located in the "Presumptive Drug Class Screening" section.

If a drug is not listed in Class A or B AND it is **not** performed by TLC (thin layer chromatography), then you are to use code 80304 unless the specific analyte is listed in the Chemistry Section (Codes 82009-84830) of the code book.

Drug Class A - usually performed by methods such as direct optical observation (e.g., dipsticks, cards etc.) or by instrumented test systems (e.g., immunoassay analyzers).

Drug Class B - methods such as ELISA or RIA would represent this section as these methods require more resources to perform the service over the Class A methods.

ALL drug class immunoassays are considered presumptive, whether qualitative, semi-quantitative, or quantitative values are provided.

These new codes identified as Presumptive Drug Class will represent the routine drug screening (i.e. urine drug screens) based on the Drug Class and the method used to test that drug.

Five codes (80300-80304) describe *presumptive drug class screening*, according to whether the drug falls into "drug class A" or "drug class B."

Dozens of new codes describe definitive drug testing. The codes are assigned according to the specific substance tested.

2015 Drug Testing for Medicare claims

Presumptive Drug Testing

For Medicare, drug screening codes are the same as last year.

- G0431 - Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
- G0434 - Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter
- G6058 - Drug confirmation, each procedure

Definitive Drug Testing

Both CPT and Medicare developed new codes for individual non-therapeutic drug assays. The new CPT codes are CPT codes 80320 – 80377. CPT clarifies that these codes are to be used for complex definitive methods such as those involving mass spectrometry and specifically excludes immunoassay and enzyme assay testing methods.

There is a Definitive Drug Classes Listing table in your CPT manual that outlines the Codes, Classes and Drugs for billing purposes.

The new HCPCS codes describing individual drug assays accepted by Medicare for 2015 are HCPCS codes G6030 – G6058. So far Medicare has not provided any real guidance on the use of these codes, such as if they are limited to particular testing methodologies.

- G6039 Acetaminophen
- G6040 Alcohol (ethanol); any specimen except breath
- G6041 Alkaloids, urine, quantitative (includes quantitative codiene)
- G6030 Amitriptyline
- G6042 Amphetamine or methamphetamine
- G6043 Barbiturates, not elsewhere specified (including amobarbital)
- G6031 Benzodiazepines
- G6044 Cocaine or metabolite
- G6032 Desipramine
- G6045 Dihydrocodeinone
- G6046 Dihydromorphinone
- G6047 Dihydrotestosterone
- G6048 Dimethadione

- G6034 Doxepin
- G6049 Epiandrosterone
- G6050 Ethchlorvynol
- G6051 Flurazepam
- G6035 Gold
- G6036 Imipramine
- G6052 Meprobamate
- G6053 Methadone
- G6054 Methsuximide
- G6055 Nicotine
- G6037 Nortriptyline
- G6056 Opiate(s), drug and metabolites, each procedure (including nalorphine)
- G6057 Phenothiazine (including chlorpromazine)
- G6038 Salicylate (including aspirin)

Chemistry

There are several parenthetical notes that now direct us to use the appropriate definitive drug testing codes outlined above.

Microbiology

Three new codes (87505-87507) describe infectious agent detection of gastrointestinal pathogen by nucleic acid (deoxyribonucleic acid (DNA) or ribonucleic acid (RNA)). Codes are assigned according to the number of types/subtypes for which testing is performed.

HPV

New codes similarly describe detection by nucleic acid (DNA or RNA) for Human Papillomavirus (HPV) (e.g., 87623 Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44).

Reproductive Medicine

There is finally a code for the cryopreservation of mature oocyte(s). That code for 2015 will be 89337.

Medicine Changes

Vaccinations

There are new vaccine codes report Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use (90630); and

Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use (90651).

90654 was changed and now reads: Influenza virus vaccine, trivalent (IIV3) split virus, preservative-free, for intradermal use.

Cardiac Device Evaluations

Guidelines and definitions that apply to codes 93260, 93261, and 93279-93299 have been revised to show the difference between S-ICD and transvenous ICD procedures.

93260 Programming device evaluation (in person) with iterative adjustment….*implantable subcutaneous lead defibrillator system*.

Echocardiography

There is a new code for transesophageal echocardiography (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s)- (93355).

Cardiac Catheterization

Because of the new code 0345T for *percutaneous transcatheter mitral valve repair*, there are some new parenthetical notes with the following codes showing the codes cannot be billed together – (93451, 93454, 93456, 93461, and 93462).

Electrophysiological Procedures

Since category III codes 0319T-0328T have been deleted, there are new category I codes that replace those previous S-ICD codes. 93644 is the S-ICD code for the electrophysiologic evaluation of an S-ICD.

Central Nervous System Assessments

A new code for brief emotional/behavioral assessment, with scoring and documentation using standardized instrument (96127).

96127 was established to report the administration of a standardized behavioral and emotional assessment instrument (eg, depression inventory, attention-deficit/hyperactivity disorder (ADHD scale) primarily for, but not limited to children and adolescents.

In turn, 96110 was revised to better distinguish it from code 96127.

96110 Developmental screening (developmental milestone survey, speech and language delay screen)...

96127 Brief emotional/behavioral assessment (depression inventory, ADHD scale…

Wound Care Management

Negative pressure wound therapy codes 97605 (area 50 square centimeters or less) and 97606 (area greater than 50 square centimeters) describe vacuum assisted drainage collection using durable medical equipment (DME).

New codes 97607 and 97608 describe the same procedure using disposable equipment.

Other Special Procedures

New hypothermia initiation code 99184 (initiation of selective head or total body hypothermia in the critically ill neonate) replaces 99481 and 99482, which are deleted from the E/M section for 2015.

99188 Application of topical fluoride varnish by a physician or other qualified healthcare professional – cannot be reported if performed by ancillary staff

Modifiers

There are four new modifiers, referred to as -X{EPSU} modifier, as well as new definitions — related to the introduction of the -X{EPSU} modifiers — in the long descriptor for modifier 59 *Distinct procedural service*.

CPT defines the -X{EPSU} modifiers as, "HCPCS modifiers for selective identification of subsets of Distinct Procedural Services [-59 modifier])." The Centers for Medicare & Medicaid Services (CMS) similarly defined the -X{EPSU} modifiers, announced in CMS Transmittal 1422, Change Request 8863, as "subsets of distinct procedural services (-59 modifier)."

XE Separate encounter
XS Separate structure
XP Separate practitioner
XU Unusual non-overlapping service

The intent of the -X{EPSU} modifiers is to require providers to specify the circumstances that call for separate reimbursement of the reported services, which generally would not be reported together.

For example, excision of skin lesions include simple repair at the same location; however, if a repair occurs at a separate location from the lesion excision, you may report the procedures independently by appending an appropriate modifier. Beginning January 1, 2015, for Medicare claims, append modifier XS to the repair code (rather than modifier 59) to indicate "separate structure."

There are specific codes sets for which CMS will require the X{EPSU} when clarity is required. The X{EPSU} will not replace modifier 59 in all instances of reporting.

If you find a code that might be of interest to you, take a second and "Google" that CPT code – you might even find more information online than you did in this article – Good coding,

Steve Adams

References:

AMA 2015 CPT Professional
AMA CPT Changes 2015: An Insider's View
NAMAS Coding Revolution
CMS 2015 Proposed Physician Fee Schedule
AAPC CPT Coding Changes