

## 2017 CPT®/HCPCS Updates and Impact on Billing

Tuesday January 24, 2017 1400-1500  
Thursday January 26, 2017 0800-0900

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- 2017 Current Procedural Terminology (CPT®) updates
- Take action on code changes
- Overview of the new, revised, and deleted 2017 CPT®/ Healthcare Common Procedure Coding System (HCPCS) Codes
- Review documentation requirements for the new codes
  - Telemedicine
  - Moderate sedation
  - Evaluation and Management (E/M)
  - Integumentary and Musculoskeletal systems
- Understand how this update will impact the billing and coding
  - CMS 1500/837P, Checklist, FAQs
  - Prior authorization of new and revised CPT®/ HCPCS codes
  - Explanation of Benefits (EOB)
  - Tips on How to Track Denials
- Resources

- There are over 700 CPT®/HCPCS code changes. Significant code changes are in the surgery section
- The American Medical Association (AMA) updates CPT® codes annually, effective 1 January
- The Centers for Medicare & Medicaid Services (CMS) updates HCPCS codes on a quarterly basis
- The Military Health System (MHS) updates CPT®/HCPCS codes annually, however, they are generally not loaded into systems until 2<sup>nd</sup> Quarter of the new Fiscal Year (FY)/ 1<sup>st</sup> Quarter of the calendar year
- The MHS Outpatient Itemized Billing (OIB) rates for new 2017 codes will not be available until mid-year (generally 1 July). MTFs can only bill if there is a DHA UBO rate for a code that is effective on the date of service
  - DHA UBO rates cannot be applied retroactively
  - Can create missed opportunities for billing

● New Code

▲ Revised Code

# Out-of-Numerical Sequence Code (re-sequenced code)

+ Add-on Code

~~⊙ Moderate Sedation~~

★ Codes to which the modifier is applicable are also denoted with a star symbol in the body of the CPT® manual.

⚡ codes for vaccines that are pending FDA approval  
words with a ~~strike through~~ are deleted in 2017

## Coding Department Supervisors:

- Order 2017 codebooks
- Archive previous year manuals

## Coders:

- Review 2017 CPT® code changes
  - Review all changes to guidelines, rules and policies in your manual
  - Highlight and review all changes in the index and tabular sections that pertain to your specialty
  - Review updates in coding tools (e.g., Encoder, CPT® assistant, Find-A-Code)
    - Seek access to tools from specialty groups (e.g., American Congress of Obstetrics and Gynecology (ACOG))
- Attend your local, regional and national conferences to stay abreast of changes
- Review Coding Clinic® determinations of updated ICD-10 code use
- Follow the MHS Professional Services and Specialty Medical Coding Guidelines for any exceptions to industry rules

## Clinical Documentation Improvement (CDI) Specialists:

- Create a documentation 'cheat sheet' of 2017 updates that affect provider documentation and distribute to providers, coders, and billing personnel
- Provide formal training on new policies
- Review internal audit processes to ensure that 2017 updates are being evaluated for accuracy

## Billing Personnel:

- Review all new payer policy changes that pertain to the 2017 updates by contacting the payer directly
  - Determine if payer rules apply to your specialties
  - Ensure payer requirements are understood by all billers
- Formulate and improve processes of tracking provider and coder queries
- Review updates and changes in online billing software tools
- Review claims prior to submission and query coders on any inconsistent utilization of codes

## TRICARE Definition:

- ‘Telemedicine utilize information and telecommunications technology to transfer medical information for diagnosis, therapy and education. The information may include medical images, live two-way audio and video (e.g., video-conferencing), electronic patient medical records, output data from medical devices and sound files. The telemedical interaction may involve two-way live audio and video visits between patients at the “originating site” and medical professionals at the “distant site.”
- Modifier 95- *‘synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system’*

## Additions:

- Appendix F added
- New icon- star
- Moderate sedation icon has been removed
- G0507- G0509: Telehealth consultations for patients requiring critical services
- 99497-99498: Advanced care planning
- 90967-90970: End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day



## Additions:

- 99151- 99157

## Revision:

- G0500: Moderate sedation services provided by the same physician or other qualified professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-services time; patient age 5 years or older
  - Add on code 99153 per HCPCS guidance: "(additional time may be reported with 99153, as appropriate)"

## Deletions:

- Appendix G removed
- Bulls eye symbol removed

HCPCS	CY 2016 Work RVU	CY 2017 Work RVU
10030	3.00	2.75
19298	6.00	5.75
20982	7.27	7.02
20983	7.13	6.88
22510	8.15	7.90
22511	7.58	7.33
22512	4.00	4.00

- UBOs should be aware of changes in relative value units (RVUs). You may see a change in cost of services
- Do not use G0500 to report moderate sedation with above codes
  - Billing personnel should ensure that claims do not go out with code G0500

## Additions:

- 96160 - 96161

## Deletions:

- 99420: Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)

## Deletions:

- 11752: Excision of nail and nail matrix, partial or complete (e.g., ingrown or deformed nail) for permanent removal; with amputation of tuft of distal phalanx
  - Use CPT codes 26236, 28124, 28160

## Revisions:

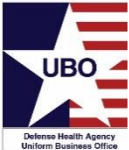
- 20240, 20245, 28289, 28296

## Deletions:

- 21495, 22305, 22815, 27193, 27194, 27193, 27194, 28291

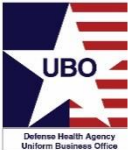
## Additions:

- 22853, 22854, 22859, 22867-70, 27197-8

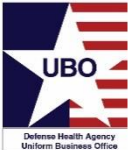


# New, Revised, and Deleted CPT®/HCPCS Codes Affecting the MHS Revenue Cycle

- Each year the code changes impact both coding and billing
- New, revised and deleted CPT®/HCPCS codes impact everyone along the revenue cycle
- Share this information with your providers
- Providers document the patient encounter and then pass on to coders, then billers, then third-party insurance companies, pay patients, other government agencies, or other parties tortuously liable for the cost of the medical care
- UBOs must produce true and correct bills
- Each area of the Revenue Cycle works together to collect the information that pertains to the patient encounter



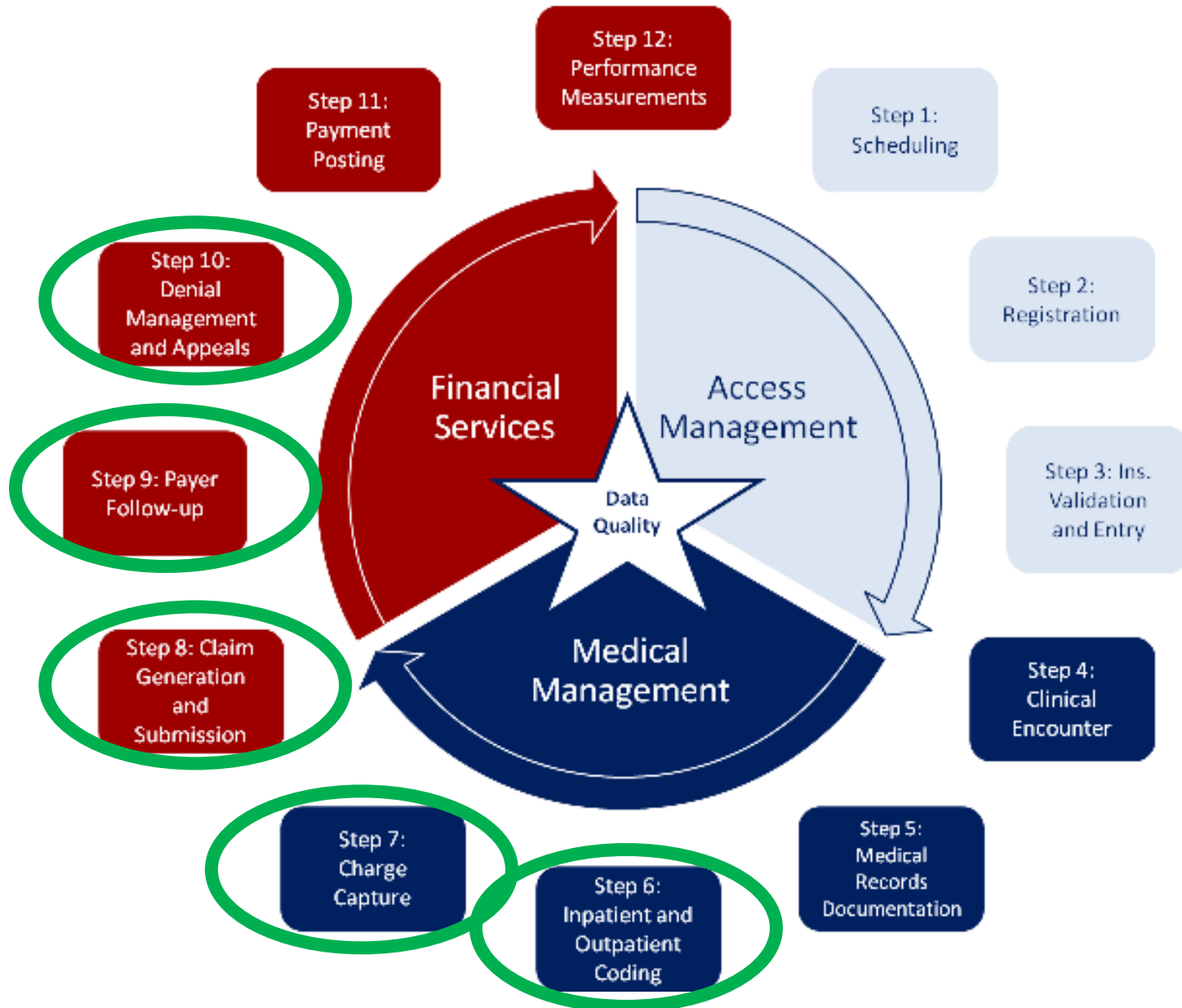
- That information creates a picture for the third party insurance payer of what services were provided during that episode of care
  - Insurance companies often deny claims when they contain old/outdated/deleted codes
- Each area of the Revenue Cycle has rules and guidelines they must follow
- Understanding and knowing the coding, billing and payer guidelines help claims to get paid compliantly, accurately and timely
- Health Affairs (HA) Policy Use of CPT<sup>®</sup> Code 99199 (14 Sept 2004)
  - Institutional component of an Ambulatory Procedure Visit (APV)
- It is crucial for billers and coders to have good communication



- The DHA UBO and DHA MCPO have guidelines for the Services and NCR MD to follow
- Billers and Coders need to work together to give the “story” of the encounter in the codes required by the third-party payer
- Each area of the Revenue Cycle has rules and guidelines they must follow:
  - To register a patient,
  - Provide services,
  - Code for the patient care and
  - Bill for patient’s services



# New, Revised, and Deleted CPT®/HCPCS Codes Affecting the MHS Revenue Cycle



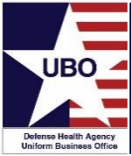
How do I find the billing guidelines for new and revised CPT®/HCPCS Codes?

- Individual payer manuals, usually available on payer websites
- Resources such as The Uniform Billing (UB) Editor (gives information on what data elements are required/situational for each field locator on the UB-04) (Published by: Optum)
- DHA UBO User Guide:

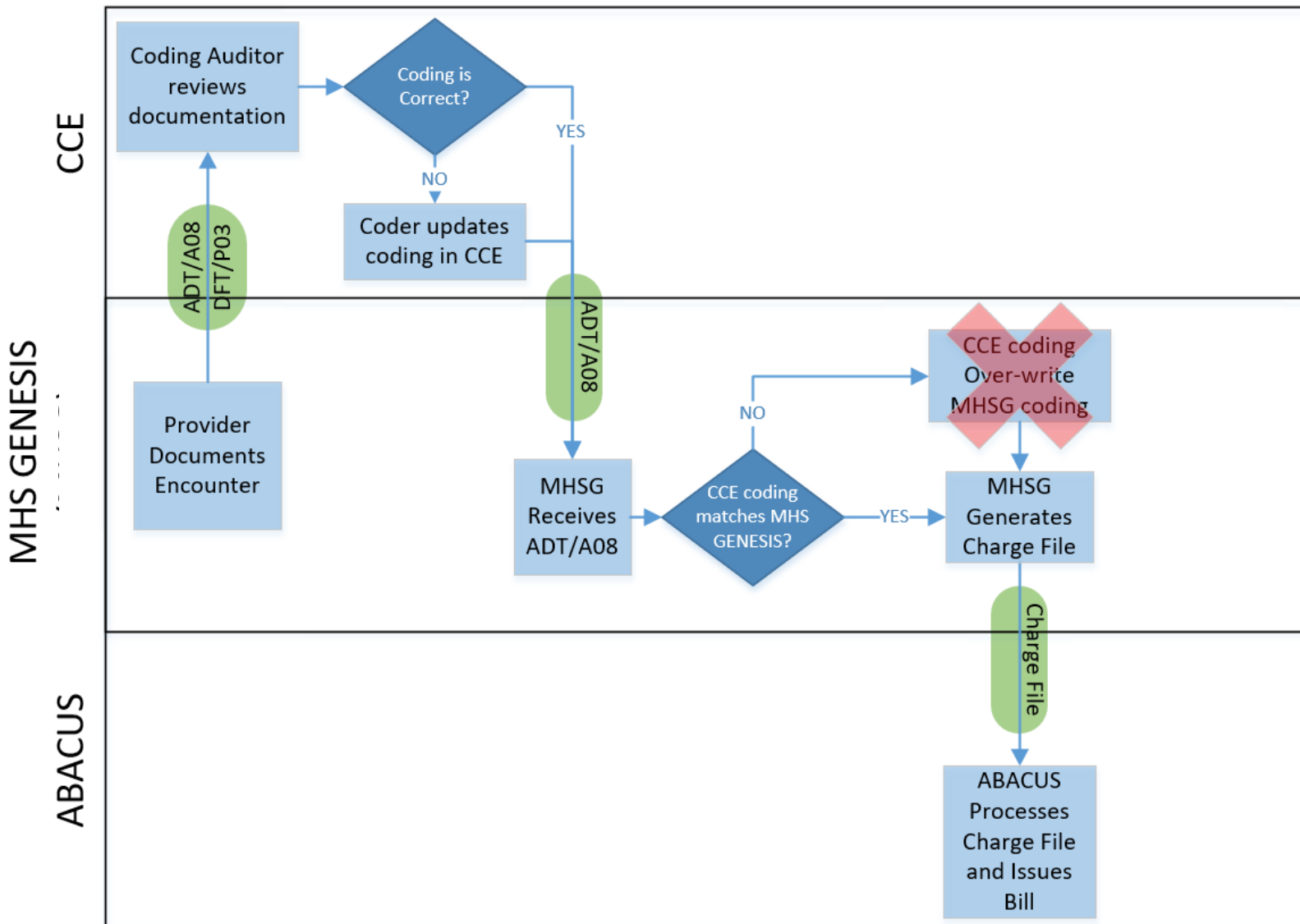
<http://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office>

- DHA UBO self paced on demand web-based trainings entitled:
  - Data and Billing in Sync: UB-04/837I
  - Data and Billing in Sync: CMS 1500 (02/12) 837P

- CPT®/HCPCS Updates may cause delays in coding due to a slight learning curve as providers and coders learn accurate usage of new codes. Potential coding delays and backlogs can impact timely filing for claims submissions
- Changes in codes may increase the number of provider queries and therefore further delay claims billing
- Health plans also need to map new and revised codes against medical policy, claims edits, and reimbursement methods. Potential payment delays may result as payers update their systems with the 2017 code changes
- There may be an increase in code edits which further lead to delays in billing
- As coders learn correct use of codes there could be a noticeable decrease in collections as a result of denials based on incorrect code use



# CPT®/HCPCS Codes Affect Billing Cont. Information Flow: To-Be-Process



- CPT® and HCPCS codes are placed on the CMS 1500 or the professional claim format, 837P, which is published and updated by National Uniform Claims Committee (NUCC): <http://www.nucc.org/index.php/1500-claim-form-mainmenu-35/nucc-data-set-and-1500-837p-crosswalk-mainmenu-49>
- Item 24d: Required, Procedures, Services, or Supplies  
[CPT®/ HCPCS code, including modifiers when applicable, for the procedures, services, or supplies furnished to the patient]
- Item 24e: Diagnosis Pointer  
[Pointer number (1–4) from Item 21 (diagnoses) that is applicable to that specific procedure, service, or supply furnished. Do not use commas between the numbers.]
- Item 24f: Required, Charges  
[Refers to the total billed amount for each service line. Do not enter dollar signs.]



- Each line item must match medical coding data
- Look out for the term “bundling” as part of the denials in EOBs. This term refers to coding related medical services as one inclusive procedure, in contrast to submitting claims for separate services
  - Especially important with the changes in CY17 where moderate sedation has been removed from over 400 codes
  - E.g., CPT codes 99151- 99157
- Individual MTF UBOs are not authorized to make coding changes. However, if a claim is denied due to bundling, the biller is encouraged to contact and request the coding department to review the encounter and update it if necessary



- Create manual bills for “missed opportunities” such as:
  - Incorrect patient category (PATCAT), expired benefits, etc.
  - Visit data must be compiled from the various modules
    - Ambulatory Data Module (ADM) for office visits
    - Lab Inquiry for Laboratory Tests
    - Exam Inquiry for Radiology Exams
    - Prescription History for Filled Prescriptions



# Billing Checklist for New, Revised, and Deleted CPT®/HCPCS Codes

## Cont.

- For new and revised codes, you should not bill services, supplies and pharmaceuticals if there is no DHA UBO rate
- However, under certain circumstances the DHA UBO Program Office (PO) will review an out-of-cycle request and may assign a rate (e.g., if there is a TRICARE or CMS rate or allowable reimbursement)
  - Must provide a written justification and supporting documentation for the recommended charge to [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org)



- The DHA UBO pricing SME will review and, if verified, submit the recommended charge and supporting justification/documentation (including no charge if insufficient justification and documentation) to the DHA UBO PO for review and approval
  - Factors considered include the number of times a service or supply code is being used or how often a pharmaceutical is dispensed and whether similar requests have been received
- Approval of a rate is MTF or Activity-specific and cannot be used by other MTFs/Activities unless the DHA UBO PO states otherwise



- If a new code is not listed in the Rate(s) Table, how do we get a code added?
  - If you have a new code that is not in the applicable rate table send an e-mail to the [UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org) with the specific code information and date of service in question. We will research whether there is or should be a rate for that code.
- If a patient's date of service was in CY 2016, but the claim is filed in CY 2017, what codes are used?
  - Use the CPT®/HCPCS codes that are effective on the date of service.



- What do I do if a claim is denied because the code has been deleted in CY 2017 or an incorrect code was used?
  - If a code is deleted, depending on the deployment of the replacement code(s)/rates will determine if you have to accept the denial.
  - New codes effective rates for DHA UBO is 1 July, annually
  - If an incorrect code is used, billers should not change the codes, but work with the coding department to determine a better/correct code to be used AND the code must be effective on the date of service.



- Payers require prior authorization for certain new and revised CPT and HCPCS codes
  - Claims without authorization may be rejected by payers
  - This has the potential to impact TPCP revenue as well as Medical Services Account (MSA) collections, e.g., VA collections, and Medical Affirmative Claims (MAC)
- The exact list of codes that require prior authorization varies depending on payer, therefore you will need to contact each payer to obtain specific requirements
  - Each payer has its own set of procedures for obtaining authorization
- CMS 1500 / 837P - Item 23 Prior Authorization Number, Required, if applicable  
[Prior authorization number for those procedures requiring prior authorization such as referral number, mammography pre-certification number, as assigned by the payer for the current service]

- Unique case: TRICARE maintains its own comprehensive Prior Authorization and Medical Necessity List for pharmaceutical codes
- Available Online at: <https://www.express-scripts.com/static/formularySearch/2.6/#/formularySearch/drugSearch?accessLink=FSTResults>



## TRICARE Formulary Search Tool

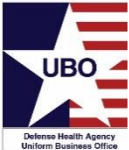
Help us to accurately determine your coverage. Please provide the following information.

I would like to search for a drug as a

Male  Female age  ▼

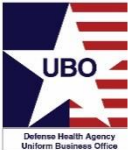
**Search »**

Copy Ctrl+C



# Denials from New, Revised and Deleted CPT®/HCPCS Codes EOB (Explanation of Benefits)

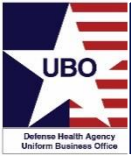
- An EOB or Remittance Advice (RA) is a document issued by the payer stating the status of the claim; whether it is paid, suspended (pending), rejected, or denied
  - Particularly important with the changes made each year to CPT®/HCPCS codes
- The purpose is to provide detailed payment information relative to the claim and, if applicable, to describe why the total original charges have not been paid in full
- Service/product description: what services the patient received from the provider
- Dates patient received service/product: when the patient received services (month/day/year to month/day/year)
- Charges billed by provider: amount billed to the patient and your healthcare plan(s)



# Denials from New, Revised and Deleted CPT®/HCPCS Codes

## EOB (Explanation of Benefits) Cont.

- Provider's fee adjustment: difference between "charges billed by provider" and the amount providers have agreed to accept as full payment; see "Message Codes" at the bottom of your EOB for details
- Copay, deductible or amount not covered: "copay" is the amount the patient pays the provider for a visit/service; "deductible" is the amount the patient pays toward covered services each year before the third party payer starts paying for services, unless services are covered without applying the deductible; "amount not covered" applies to services/products not covered by the plan; see "Message Codes" at the bottom of the EOB for details.
- Total amount eligible for benefits: charges billed by provider minus provider fee adjustment minus patient copy, deductible or amount not covered
- %: percentage level of benefits for covered services/products
- Patient coinsurance amount: what the patient must pay the provider after insurance pays the covered percentage
- Adjustment: see explanation(s) at the bottom of the EOB for details.
- Total paid by your plan: "total amount eligible for benefits minus coinsurance amount
- Amount patient responsible for: what the patient must pay of the billed charges after the plan benefits are paid



# Denials from New, Revised and Deleted CPT®/HCPCS Codes EOB (Explanation of Benefits) Cont.

## EXPLANATION OF BENEFITS

Dec 01, 2005

**SAMPLE**

Group Number: 12345678  
 Member: John Sample  
 Member's ID: 1000017-01  
 Claim Number: 800000001  
 Provider: Smith, Robert  
 Payment Reference ID: 2002062510100013

(This is NOT a bill)

① Service/ product description	② Dates you received service/product (m/d/y to m/d/y)	③ Charges billed by provider	④ Minus provider's fee adjustment (*)	⑤ Minus your copay (C), deductible (D) or amount not covered (**)	⑥ Total amount eligible for benefits	⑦ %	⑧ Minus your coinsurance amount	⑨ Plus or (minus) adjustment	⑩ Total paid by your plan	⑪ Amount you're responsible for
OFFICE VISIT	11/15/05 11/15/05	75.00	12.00 PDC	15.00 C	48.00	100%			48.00	15.00
LAB	11/15/05 11/15/05	89.12	15.36 PDC	50.00 D	23.76	100%			23.76	50.00
X-RAY	11/15/05 11/15/05	100.00	20.00 PDC		80.00	80%	16.00		64.00	16.00
SURGERY	11/15/05 11/15/05	50.00		50.00 \$75	0	0%			0.00	50.00
Totals		\$314.12	\$47.36	\$115.00	\$151.76		\$16.00		\$135.76	\$131.00

Amount you're responsible for: \$131.00

Your 2005/Plan Year Medical Deductible satisfied so far: \$100.00

Your 2005 Plan Year Family Medical deductible satisfied so far: \$300.00

Amount you're responsible for: \$131.00

Message Codes:

PDC AGREEMENT DISCOUNT

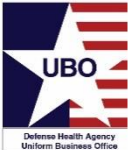
575 THIS PROCEDURE IS CONSIDERED COSMETIC. YOUR PLAN DOESN'T COVER COSMETIC SERVICES.

Z48 NOTE: WHEN YOU RECEIVE SERVICES FROM A NON-PREFERRED PROVIDER, WE MAY PAY BENEFITS DIRECTLY TO YOU. IF SO, YOU WILL NEED TO MAKE ARRANGEMENTS TO REIMBURSE THE PROVIDER.

Z49 NOTE: WHEN YOU RECEIVE SERVICES FROM A NON-PREFERRED PROVIDER, WE MAY PAY BENEFITS DIRECTLY TO YOU. IF SO, YOU WILL NEED TO MAKE ARRANGEMENTS TO REIMBURSE THE PROVIDER.



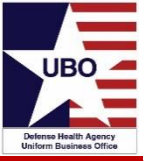




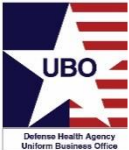
# Denials from New, Revised and Deleted CPT®/HCPCS Codes

## Tips for Tracking Denials

- Helps identify which CPT® / HCPCS codes are incorrectly used
- Defines where breakdowns are in the process to identify opportunities for performance improvement
- Identifies unreasonable payer practices associated with code revisions
- Collaborative effort appeals are easier to handle in the future
- Identifies areas where denials management efforts have been successful
- There is also a denials management webinar that can be referenced at <http://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center>



- Familiarize yourself with changes in CPT®/HCPCS codes in 2017
- Proper billing codes are required for payers to reimburse claims
- Understanding how new and revised codes can impact reimbursement and create denials is important
- Be sure to understand the denial codes on the EOB
- Focus on effective communication with coders and payers
- Develop a strategic plan for managing individual claim denials
- For a more in depth study of the data elements required on the UB-04/837I and CMS 1500/ 837P claim form, please visit the DHA UBO Learning Center website <http://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center>

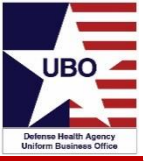


- Title 10, United States Code, Section 1095
  - Authorizes the government to collect reasonable charges from third party payers for health care provided to beneficiaries.
- Title 32, Code of Federal Regulations, Part 220
  - Implements 10 U.S.C. 1095 and specifies:
    - Statutory obligation of third party payers to pay; no assignment of benefits required
    - Certain payers excluded from Third Party Collection Program (TPCP)
    - Applicable charges
    - Rights and obligations of beneficiaries
    - Special rules for Medicare supplemental plans, automobile insurance, and workers' compensation programs

- **CPT®/HCPCS 2017 ADDED AND DELETED CODES**



Microsoft Excel  
97-2003 Worksheet



- Refer to industry guidelines found on payer websites
- Refer to DHA UBO guidance
  - DHA UBO User Guide
  - DHA UBO Website:  
<http://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center>
- And  
<https://info.health.mil/SitePages/Home.aspx>
- Refer to Service and NCR MD specific guidelines
- DHA UBO Helpdesk
  - [Email: UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org)
  - Phone: 1(202)-776-1532



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  - Complete a post-test available *within* the archived webinar
  - E-mail answers to [UBO.LearningCenter@altarum.org](mailto:UBO.LearningCenter@altarum.org)
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