

2019 CPT®/HCPCS Updates and Impact on Billing

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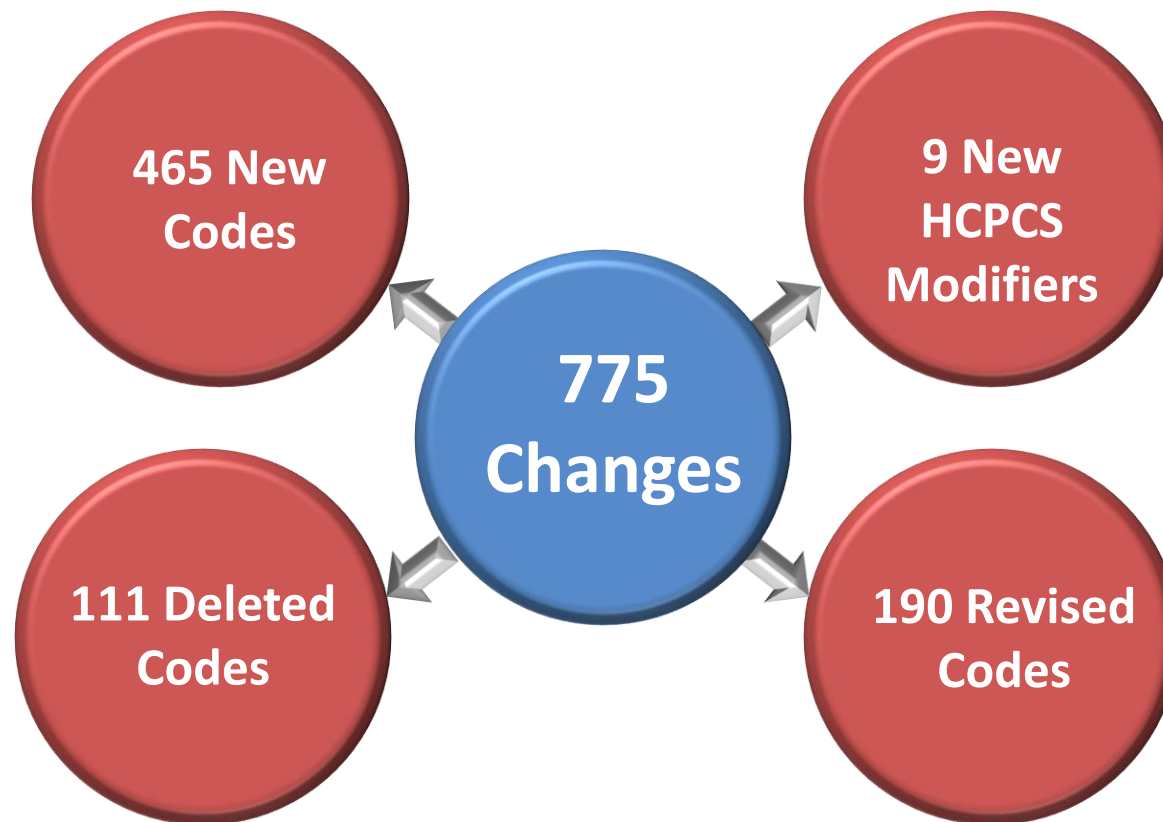
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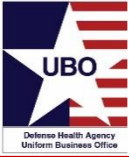
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- Changes to Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) Codes
- Effective Dates and Symbols for 2019 CPT® Code Changes
- Proposed Action for Code Changes
- Overview of the new, revised, and deleted 2019 CPT®/HCPCS Codes
- Impact of New, Revised, and Deleted CPT®/HCPCS Codes on the MHS Revenue Cycle
- Billing Guidelines
- Billing Best Practices for New, Revised, and Deleted CPT®/HCPCS
- Billing for New and Revised CPT®/HCPCS Codes – Prior Authorization
- Denials from New, Revised and Deleted CPT®/HCPCS Codes Tips for Tracking Denials
- Billing Frequently Asked Questions for New, Revised, and Deleted CPT®/HCPCS
- Summary
- Background
- Resources

There are over 700 code changes. Changes to CPT®/ HCPCS are effective January 1st, 2019





- American Medical Association (AMA) updates CPT® codes annually, effective *1 January*
- Centers for Medicare & Medicaid Services (CMS) updates HCPCS codes on a *quarterly* basis
- Military Health System (MHS) Coding Guidelines were last updated in August 2017
- DHA UBO Outpatient rates for 2019 CPT®/HCPCS codes *generally effective 1 July*
 - For the DHA UBO Outpatient 2019 **NEW** codes, rates are not currently available at this time. DHA UBO Program Office has begun implementation of an out-of-cycle update for more billing opportunities with an effective date of 1 January 2019 once loaded into ABACUS
 - DHA UBO rates cannot be applied retroactively

- **Bullet symbol** - located to the left of CPT® codes that identifies new procedures and services
- ▲ **Triangle symbol** - located to the left of CPT codes that identifies revised/modified code descriptions
- + **Plus symbol** - located to the left of CPT codes that identifies add-on codes (also located in Appendix D of CPT®) for procedures that are commonly, but not always, performed at the same time and by the same surgeon as the primary procedure
- ★ **Star symbol** - Indicates a telemedicine code
- ⚡ **Flash symbol** - located to the left of CPT codes that identifies vaccines pending FDA approval but that have been assigned a CPT code

Codes with a ~~strike-through~~ are **deleted codes**

Words with a ~~strike-through~~ are called "**changed codes**" and can alter the use of the code

Added wording in a **revised/modified** code is underlined and can also alter the use of the code

⊘ **Cancel Sign**- indicates a code that is exempt from the use of modifier 51 but is not designated as a CPT add-on procedure or service

▶◀ **Green text within green arrows** - indicates revised guidelines, cross-references, and/or explanatory text

Pound sign - indicates a resequenced code

⎵ **Duplicate PLA Test symbol** - indicates a duplicate PLA test



Coding Department Supervisors:

- Order 2019 codebooks
- Archive previous year manuals

Coders:

- Review 2019 CPT® code changes
 - Review all changes to guidelines, rules and policies
 - Highlight and review all changes in the index and tabular sections that pertain to specialty
 - Review updates in coding tools (e.g., CCE, EncoderPro, CPT® Assistant, Find-A-Code)
 - Seek access to tools from specialty groups (e.g., American College of Obstetrics and Gynecology (ACOG))
- Attend local, regional and national conferences to stay abreast of changes
- Review AHA Coding Clinic® determinations of updated ICD-10-CM/HCPCS code use
- Follow the MHS Professional Services and Specialty Medical Coding Guidelines for MHS specifics and any exceptions to industry rules (e.g., CMS)

Clinical Documentation Improvement (CDI) Specialists:

- Create a documentation 'cheat sheet' of 2019 updates that impact provider documentation and distribute to providers, coders, and billing personnel
- Provide formal training on new, modified and deleted codes and the MHS policies impacted
- Review internal audit processes to ensure that 2019 updates are evaluated for accuracy as well as the Coding Compliance Plan, e.g. Review and update internal audit processes and plans to ensure that all documents are consistent with 2019 updates

Billing Personnel:

- Review new payer policy changes that pertain to the 2019 updates
 - Determine if payer rules apply
 - Ensure payer requirements are understood by all billers
- Formulate and improve processes for coordinating with HIM department to track 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

Overview of the New, Revised, and Deleted 2019 CPT[®]/HCPCS Codes

Revised:

- 99446 , 99447, 99448, 99449, 99091
 - Interprofessional Telephone/Internet Consultation: electronic health record added and guidelines revised (99446-99449)
 - Collection and interpretation of physiologic data (99091) resequenced to this new subsection from Medicine Miscellaneous

New:

- 99451, 99452, 99453, 99454, 99457, 99491
 - Interprofessional consultation/referral services provided by a consultative physician or by treating/requesting physician or other qualified healthcare professional (99451 and 99452)
 - Used to report remote physiologic monitoring services (e.g. weight, blood pressure, pulse oximetry) during a 30-day period (99453 and 99454)
 - Used to report remote physiologic monitoring treatment management services for 20 minutes or more in a calendar month (99457)
 - Used to report chronic care management provided by a physician/QHP of at least 30 minutes per calendar month

Revised:

- 10021, 36568, 36569, 36584, 61641, 61642, 74485, 77021, 77022, 77387, 81162, 81212, 81215-81217, 81244, 81287, 81327, 81400, 81401, 81403-81405, 81407, 0006U, 93279, 93285, 93286, 93288, 93290, 93291, 93294, 93296-93299, 94780, 94781, 95970-95972, 96116, 99446-99499, 99091, 0335T, 0362T, 0373T

New:

- 10004-10012, 11102-11107, 20932-20934, 27369, 33274, 33275, 33285, 33286, 33289, 33440, 33866, 36572, 36573, 38531, 43762, 43763, 50436, 50437, 53854, 76391, 76978, 76979, 76981-76983, 77046-77049, 81163-81167, 81171-81174, 81177-81183, 81204, 81233, 81184-81190, 81234, 81236, 81237, 81239, 81271, 81274, 81284-81286, 81289, 81305, 81306, 81312, 81320, 81329, 81333, 81336, 81337, 81343, 81344, 81345, 81443, 81518, 81596, 82642, 83722, 90689, 91344, 91345, 92273, 92274, 93264, 95836, 95976, 95977, 95983, 95984, 96112, 96113, 96121, 96130-96133, 96136-96139, 96146, 97151-97158, 99451-99454, 99457, 99491, 0011M-0013M, 0505T-0542T, 0018U-0061U

Deleted:

- 10022, 11100, 11101, 20005, 27370, 31595, 33282, 33284, 41500, 43760, 46762, 50395, 61332, 61480, 61610, 61612, 63615, 64508, 64550, 66220, 76001, 77058, 77059, 78270, 78271, 78272, 81211, 81213, 81214, 0004U, 0015U, 92275, 95974, 95975, 95978, 95979, 96101-96103, 96111, 96118-96120, 99090, 0159T, 0188T-0190T, 0195T, 0196T, 0337T, 0346T, 0359T, 0361T, 0363T-0372T, 0374T, 0387T-0391T, 0406T, 0407T

General

- 9 codes added (10004-10012) for fine needle aspiration biopsy to include imaging guidance
- 1 code revised (10021) to specify that the procedure reported is intended as a biopsy and used to report the first lesion biopsied
- 1 code has been deleted (10022)

Integumentary

- 6 new codes (11102-11107) to describe distinct biopsy modalities: tangential, punch and incisional, and 3 add-ons
- 2 codes deleted (11100 and 11101) that previously did not distinguish biopsy techniques

Musculoskeletal

- General:
 - 1 incision code deleted
 - 3 new graft (or implant) add-on codes (20932-20934) to accurately describe allograft procedures
- Femur (Thigh region) and Knee Joint: 1 new code and 1 deleted code (27370 replaced with 27369 to include contrast enhanced CT/MRI knee arthrography)

Respiratory

- Larynx: 1 code deleted (31595)- low utilization

Cardiovascular

- Heart and Pericardium:
 - 7 new codes (33274, 33275, 33285, 33286, 33289, 33440, 33866)
 - 2 codes deleted (33282, 33284): replaced with 33285 and 33286
- Arteries and Veins
 - 3 revised codes (36568, 36569, 36584)
 - 2 new codes (36562, 36563)

Hemic and Lymphatic

- Lymph Nodes and Lymphatic Channels: 1 new code (38531)

Digestive

- Tongue and Floor of Mouth: 1 code deleted (41500)
- Stomach:
 - 2 new codes (43762 and 43763)
 - 1 deleted (43760)
- Anus: 1 code deleted (46762)

Urinary

- Kidney:
 - 1 code deleted (50395)
 - 2 codes added (50436 and 50437)
- Urethra: 1 code added (53854)

Nervous

- Skull, Meninges, and Brain:
 - 4 codes deleted (61332, 61480, 61610, 61612)
 - 2 codes revised (61641 and 61642)
- Spine and Spinal Cord: 1 code deleted (63615)
- Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System: 2 codes deleted (64508 and 64550)

Eye and Ocular Adnexa

- Anterior Segment: 1 code deleted (66220)

Revised:

- 74485, 77021, 77022, 77387

New:

- 76391, 76978, 76979, 76981-76983, 77046-77049

Deleted:

- 76001, 77058, 77059, 78270, 78271, 78272

Note:

- Addition of 9 new codes and reporting instructions for X-ray services
- Changes to Diagnostic Radiology subsection have deleted 76001 fluoroscopy and 5 new codes were added for reporting ultrasound examinations
- Additionally two codes were deleted for the addition of four codes for MRI of the breast
- Revision to the Diagnostic and Magnetic Resonance Imaging sections including Nuclear Medicine and Diagnostic Ultrasound
 - Guidelines further specify the requirements for imaging guidance codes and radiological supervision and interpretation (RS&I) codes

Revised:

- 81162, 81212, 81215-81217, 81244, 81287, 81327, 81400, 81401, 81403-81405, 81407, 0006U

New:

- 81171, 81172, 81204, 81173, 81174, 81177-81183
- 81163-81167, 81233, 81184-81190, 81234, 81239, 81236, 81237, 81284-81286, 81289, 81271, 81274, 81305, 81306, 81312, 81320, 81343, 81329, 81336, 81337, 81344, 81345, 81333, 81443, 81518, 81596, 82642, 83722
- 0018U-0061U (*Expanded code range for Proprietary Laboratory Analyses*)

Deleted:

- 81211, 81213, 81214, 0004U, 0015U

- 95 New codes
 - 46 tier 1 molecular pathology codes
 - 44 new PLA codes
 - 2 codes deleted: 0004U and 0015U
 - 1 revision: 0006U to report detection of interacting medications, substances, supplements, and food
 - 2 Cat 1 Multianalyte Assays with Algorithmic Analyses (MAAA) codes (81518 and 81596)
 - 3 administrative MAAA codes (82642, 83722, 81443)

Revised:

- 93279, 93285, 93286, 93288, 93290, 93291, 93294, 93296-93299, 94780, 94781, 95970-95972, 96116

New:

- 90689, 92273, 92274, 93264, 95836, 95976, 95977, 95983, 95984, 97151-97158, 96112, 96113, 96121, 96130-96133, 96136-96139, 96146

Deleted:

- 92275, 95974, 95975, 95978, 95979, 96101-96103, 96111, 96118-96120, 99090

Note: The Imaging Guidance subsection of the Medicine Guidelines specifies that non-imaging guided tracking or localizing systems (e.g., radar signals, electromagnetic signals) should not be separately reported

Vaccines, Toxoids

- 1 new code (90689) pending FDA approval for pediatric quadrivalent influenza

Ophthalmology

- Special Ophthalmological Services
 - 2 new codes (92273 and 92274) to replace deleted code
 - 1 code deleted (92275)

Cardiovascular

- Implantable, Insertable, and Wearable Cardiac Device Evaluations (new subsection title to include 'Insertable')
 - 1 new code (93264)
 - 11 revisions (93279, 93285, 93286, 93288, 93290, 93291, 93294, 93296-93299)
- Large number of revisions to include evaluation of leadless pacemakers and further revisions of descriptors of codes, device definitions in guidelines, and relevant parenthetical notes in the subsections were made

Pulmonary

- Pulmonary Diagnostic Testing and Therapies: 2 revised codes (94780 and 94781)
 - Neonate term replaced with “for infants through 12 months of age”

Neurology and Neuromuscular Procedures

- Electrocorticography
 - New guidelines added
 - 1 new code (95836) added for patient-provided equipment
- Neurostimulators, Analysis-Programming
 - 4 new codes added (95976, 95977, 95983, 95984), 4 codes deleted (95974, 95975, 95978, 95979), 3 codes revised (95970-95972), and 3 new tables included in multiple sections of the CPT code set to clarify reporting cranial nerve, spinal, peripheral nerve, and sacral nerve neurostimulator services

Adaptive Behavior Services

- Functional Brain Mapping, Adaptive Behavior Assessments (new subsection) and Treatment:
 - New guidelines and 8 new codes (97151-97158)
 - Adaptive Behavior Assessments: 97151 and 97152
 - Previously described by 5 Category III codes (0359T-0363T)
 - Adaptive Behavior Treatments: 97153-97158
 - Previously described by Category III codes 0364T-0369T

Central Nervous System Assessments/Tests

- Substantial revisions made to address the difference between neurological testing and examination services:
 - 7 deleted codes (96101-96103, 96111, 96118-96120)
 - 12 new codes (96112, 96113, 96121, 96130-96133, 96136-96139, 96146)
 - Addition and revision of guidelines, subsection titles, and revision of exclusionary parenthetical notes
 - 1 revised code (96116)

Special Services, Procedures and Reports

- 1 deleted code from Misc. Services (99090)

- **New HCPCS modifiers added:**

- **CO:** Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
- **CQ:** Outpatient physical therapy services furnished in whole or in part by a physical therapy assistant
- **ER:** Items and services furnished by a provider-based, off-campus emergency department
- **G0:** Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke
- **QA:** Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is less than 1 liter per minute (LPM)
- **QB:** Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts exceeds 4 liters per minute (LPM) and portable oxygen is prescribed
- **QE:** Prescribed amount of stationary oxygen while at rest is less than 1 liter per minute (LPM)
- **QR:** Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is greater than 4 liters per minute (LPM)
- **VM:** Medicare diabetes prevention program (MDPP) virtual make-up session

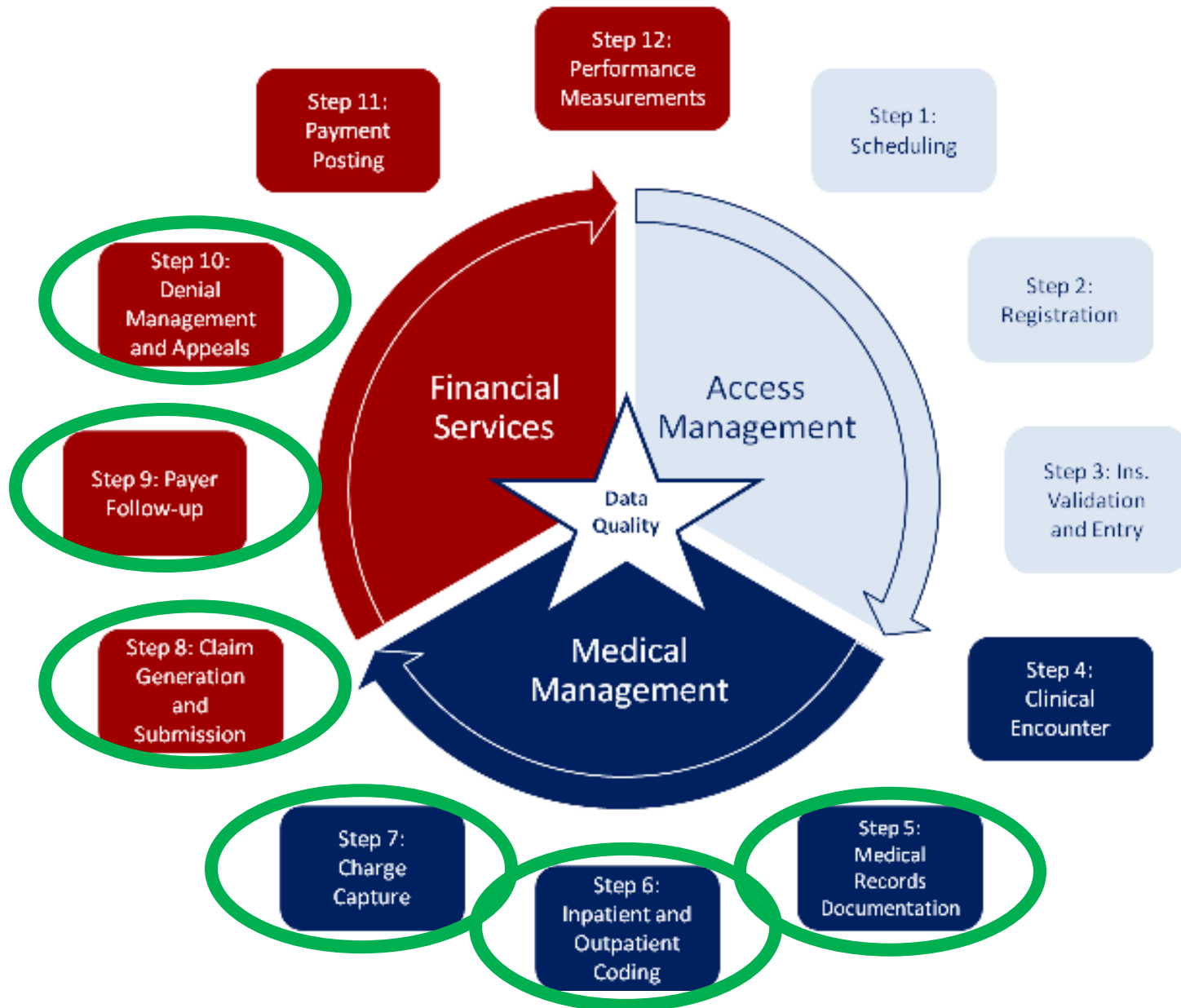
○ Recycled/reinstated modifiers:

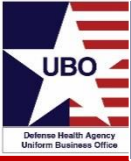
- **QQ:** Ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional

▲ Revised modifiers:

- **QF:** Prescribed amount of stationary oxygen while at rest exceeds 4 liter per minute (LPM) and portable oxygen is prescribed
- **QG:** Prescribed amount of stationary oxygen while at rest is greater than 4 liters per minute (LPM)
- **63:** Procedure performed on Infants less than 4 kg. Note: Unless otherwise designated, this modifier may only be appended to procedure/services listed in the 20100-69990 code series.
 - **Rationale:** in support of the deletion of code 20005, the code range in the descriptor for modifier 63 has been revised to begin with code 20100, which is now the first code in that section

Impact of New, Revised, and Deleted CPT®/HCPCS Codes on the MHS Revenue Cycle





Impact of New, Revised, and Deleted CPT®/HCPCS Codes on the MHS Revenue Cycle, Cont.

- Each year code changes impact both coding and billing functions
- New, revised and deleted CPT®/HCPCS codes have multiple impacts within the revenue cycle
- Share this information with your providers through cheat sheets and other established and informative communication
- Providers document the patient encounter and then pass the *billable encounters* 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



Impact of New, Revised, and Deleted CPT®/HCPCS Codes on the MHS Revenue Cycle, Cont.

Action Steps:

- Share CPT®/HCPCS changes and updates with all *relevant personnel*
- Providers *document patient encounter(s)*; pass the billable encounters on to coders -> billers -> third-party insurance companies -> pay patients -> other government agencies or other parties tortuously liable for the cost of the medical care
- Ensure that the MTF's UBOs *produce true and accurate bills*
- Promote *collaboration*: each area of the Revenue Cycle works together to collect the information that pertains to the patient encounter
- Crucial skill: effective communication
- Enforce Compliance and Accuracy: Rules and guidelines must be followed
 - Insurance companies often deny claims when they contain old/outdated/deleted codes
- Understanding and knowledge of the coding, billing and payer guidelines help claims get paid compliantly, accurately and timely

2019 Specific Impacts:

- Overall limited impact with new adds, mods, deletes
 - Deletes: Work with the users of deleted codes to identify replacement codes
 - Skin biopsies constituted 0.12% of all records; 10022, 11100 and 11101 replaced with 9 new codes for fine needle aspiration with imaging and skin biopsies
 - 190,000 records or 0.46% of all records involved the psychological/developmental/neuropsychological testing codes which were replaced with codes more aligned with actual services rendered
 - CAPER deletions list with greater than 2,000 uses: 10022, 11100, 11101, 76001, 77059, 96101, 96102, 96103, 96111, 96118, 96119, 96120, 99090, C9492, J9310, Q5102
 - Total impact of deleted codes 1.08% of all records*
 - Adds: Most new codes with impact are those replacing deleted codes
 - Of the 465 new codes, 116 are laboratory primarily for specialty genetic tests, 97 are supplies and 85 are performance measurement
 - Infrequently used codes in direct care
 - New code sets of interest for radiology support during surgeries and many new laboratory tests for rare genetic issues

*Based upon 2018 CAPER direct care data record, “Ancillary Lab and Rad” data for lab ancillary records and radiology ancillary records; excludes dental records

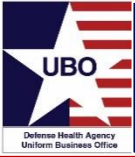
Billing guidelines for new and revised CPT®/HCPCS Codes

- Individual payer manuals, usually available on payer websites
- Electronic Resources
 - Coding and Compliance Editor, CCE
 - 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)
 - EncoderPro
 - nThrive
- 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



Billing Best Practices for New, Revised and Deleted CPT®/HCPCS Codes

- Each line item must match medical coding data
- “Bundling” may lead to denials in EOBs
 - Refers to coding related medical services as one inclusive procedure, in contrast to submitting claims for separate services
- Individual MTF UBOs are not authorized to make coding changes
 - If claim is denied due to bundling, biller encouraged to request a review of the encounter and update as necessary
- Create manual bills for “missed opportunities”
 - Incorrect patient categories (PATCAT), expired benefits, etc.
- For new and revised codes, do not bill services, supplies and pharmaceuticals if there is no DHA UBO rate
- Submit codes with justification to DHA UBO PO for review and possible rate assignment to UBO Helpdesk (UBO.Helpdesk@altarum.org)



Billing for New and Revised CPT® HCPCS Codes – Prior Authorizations

- Payers require prior authorization for certain new and revised CPT® and HCPCS codes
 - Claims without authorization may be rejected by payers
 - Potential impact to TPCP revenue and Medical Services Account (MSA) collections, e.g., VA collections, and Medical Affirmative Claims (MAC)
- Prior authorization code list varies depending on payer
 - Contact each payer to obtain specific requirements and recommended procedure
- 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

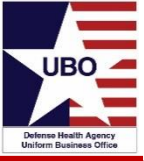
Male Female age



- If a new code is not listed in the DHA UBO Rate Table(s), how is 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 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 2018, but the claim is filed in CY 2019, 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 2019 or an incorrect code was used?
 - If a code is deleted replacement code(s)/rates will determine if you have to accept the denial
 - New codes effective rates for DHA UBO is 1 July, annually
 - The exception this year is an out of cycle update for CMAC codes from the new 2019 CPT/HCPCS release
 - If an incorrect code is used, billers will not change the codes, but work with the coding department to determine the correct code to be used AND the code must be effective on the date of service

- Changes in CPT®/HCPCS codes in 2019
- Proper billing codes are required for payers to reimburse claims
- New and revised codes can impact reimbursement and create denials
- Implement billing best practices
- Know the rules for Prior Authorizations, EOBs and Denials
- Focus on effective communication with coders and payers
- Develop a strategic plan for managing individual claim denials
- Utilize all available resources
 - MHS coding guidelines
 - Payer Requirements
 - Electronic Resources
 - DHA UBO Learning Center website <http://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center>



- 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 tIMO specific guidelines
- DHA UBO Helpdesk
 - [Email: UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org)



- American Medical Association: *Current Procedural Terminology (CPT®)2019*, Professional Edition, Chicago, 2018. The Association
- Centers for Medicare & Medicaid Services, 2019 Healthcare Common Procedure Coding System (HCPCS). www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.html



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