

2018 CPT®/HCPCS Updates and Impact on Billing

Tuesday January 23, 2018 0800-0900 EST
Thursday January 25, 2018 1400-1500 EST

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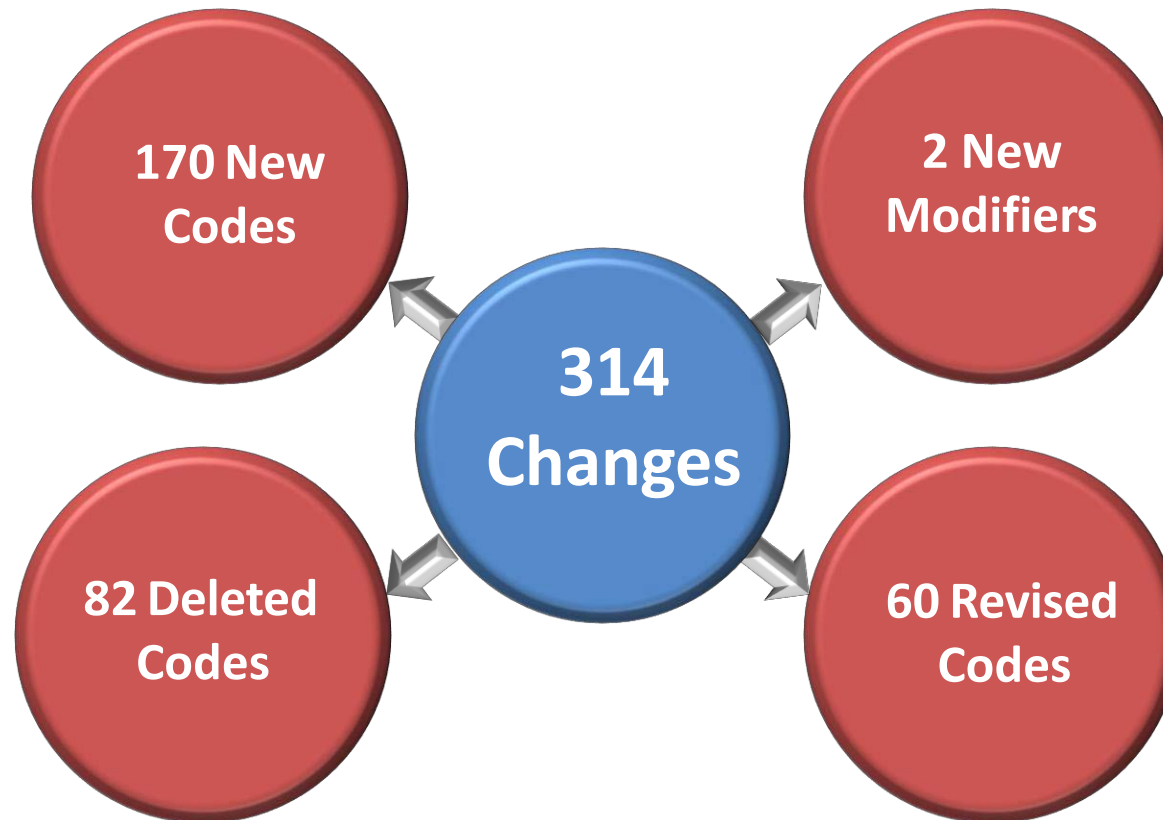
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- Changes to Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) Codes
- Effective Dates
- Symbols for 2018 CPT® Code Changes
- Proposed Action for Code Changes
- Overview of the new, revised, and deleted 2018 CPT®/HCPCS Codes
 - Evaluation and Management (E/M)
 - Anesthesia
 - Surgery
 - Radiology
 - Pathology and Laboratory
 - Medicine
 - Telehealth
- 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
- Billing for New and Revised CPT®/HCPCS Codes – Explanation of Benefits (EOB)
- 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 300 code changes. Changes to CPT®/ HCPCS are effective January 1st, 2018



- 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 updated August 2017
- DHA UBO Outpatient rates for 2018 CPT®/HCPCS codes *generally effective 1 July*
 - For the DHA UBO Outpatient 2018 **NEW** codes, rates are not currently available at this time. DHA UBO Program Office may consider an out-of-cycle update for more billing opportunities. Otherwise, rates for these codes will be released with the annual update (generally 1 July)
 - MTFs can only bill if there is a DHA UBO rate assigned for a code that is effective on the date of service
 - 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** - Codes with applicable modifier(s) are also denoted with a star symbol in the body of the description/explanation

(⚡) **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



Coding Department Supervisors:

- Order 2018 codebooks
- Archive previous year manuals

Coders:

- Review 2018 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 Coding Clinic® determinations of updated ICD-10 code use
- Follow the MHS Professional Services and Specialty Medical Coding Guidelines for MHS specifics and any exceptions to industry rules

Clinical Documentation Improvement (CDI) Specialists:

- Create a documentation 'cheat sheet' of 2018 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 2018 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 2018 updates

Billing Personnel:

- Review new payer policy changes that pertain to the 2018 updates
 - Determine if payer rules apply
 - 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

Overview of the New, Revised, and Deleted 2018 CPT[®]/HCPCS Codes

Revised:

- 99217 - 99220 Hospital Observation Services: Code descriptions changed from “admission to observation status” to “outpatient hospital observation status”
- 99483 replaces G0505
 - New “Cognitive Assessment and Care Plan Services” subsection
 - HCPCS code G0505, developed and reimbursed by CMS in 2017, is replaced with CPT code 99483 starting January 1, 2018.
- 99492, 99493 and 99494 replaces G0502, G0503 and G0504, respectively
 - New “Psychiatric Collaborative Care Management Services” subsection
- 99484 replaces G0507
 - New “General Behavioral Health Integration Care Management” subsection

Deleted:

- 99363 and 99364
 - replaced with 93792 and 93793 (assigned RVUs by Medicare)
 - Other major guidelines to follow for replacement codes, consult CPT® manual

New:

- 00731, 00732, 00811, 00812, 00813
 - Upper GI endoscopic procedures (00731 and 00732)
 - Lower intestinal endoscopic procedures (00811 and 00812)
 - Report 00812 for anesthesia for any screening colonoscopy regardless of findings
 - Combined upper/lower GI endoscopic procedures (00813)

Deleted:

- 00740, 00810, 01180, 01190, 01682

Note: Code 01680 was reformatted as a stand-alone code

Revised:

- 17250, 31254, 31255, 31276, 31645, 31646, 32998, 34812, 34820, 34833, 34834, 36140, 36468, 36470 - 36471, 36516, 36908, 38220, 38221, 43112, 57240, 57260, 57265, 64550, 76000, 76881, 76882, 80305, 80306, 80307, 81257 81400 81401 81403, 81405, 81406, 81432, 81439, 82042 - 82044, 86003, 86005, 90651, 90620, 90621, 94621, 95250, 95251, 95930, 96567, 97760, 97761, 99217 - 99220, 0254T

New:

- 00731T, 00811T, 00812T, 00813T
- 15730, 15733, 19294, 20939, 31241, 31253, 31257, 31259, 31298, 32994, 33927-33929, 34701-34716, 36465 - 36466, 36482-36483, 38222, 38573, 43286 - 43288, 55874, 58575, 64912 - 64913, 71045 - 71048, 74018 - 74019, 74021, 81175, 81176, 81230 - 81232, 81238, 81247, 81249, 81258, 81259, 81269, 81105 - 81112, 81120, 81121, 81283, 81334, 81328, 81335, 81346, 81361 - 81364, 81448, 81520, 81521, 81541, 81551, 86794, 87634, 87662, 0001U - 0017U, 90587, 90756, 93792, 93793, 94617 - 94618, 95249, 96753, 96574, 97127, 97763, 99483, 99484, 98492 - 98494
- 0488T, 0468T-0487T, 0489T, 0490T - 0504T

Deleted:

- 0051T, 0052T, 0053T, 00740, 00810, 01180, 01190, 01682, 0178T - 0179T, 0180T, 0255T, 0293T, 0294T, 0299T, 0300T, 0301T, 0302T-0307T, 0309T, 0310T, 0340T, 0438T, 15732, 29582, 29583, 31320, 21495, 22305, 22815, 27193, 27194, 27193, 27194, 28291, 34800, 34802 - 34806, 34825 - 34826, 34900, 36120, 36515, 55450, 64565, 69820, 69840, 71010, 71015, 71020, 71021 - 71023, 71030, 74000, 74010, 74020, 75658, 75952, 75953, 75954, 77422, 78190, 83499, 84061, 86185, 86243, 86378, 86729, 86822, 87277, 87470, 87477, 87515, 88154, 93982, 94620, 97532, 97762, 99363, 99364

Integumentary

- 3 codes added (15730, 15733, and 19294)
- 1 code deleted (15732)
- 1 code revised (17250)
- Multiple parenthetical note additions and revisions

Musculoskeletal

- 1 new add-on code (20939) for bone marrow aspiration for bone grafting during spine surgery only
- 2 codes deleted (29582 and 29583)

Respiratory

- Sinus Endoscopy
 - 5 new codes (31241, 31253, 31257, 31259, 31298)
 - 3 codes revised (31254, 31255, and 31276)
- Larynx: code 31320 deleted due to low utilization
- Trachea and Bronchi: codes 31645 and 31646 revised
- Lungs and Pleura: code 32994 added and 32998 revised
- New guidelines, new and revised parenthetical notes

Vascular Injection Procedures

- New and deleted guidelines
- 4 new codes (36465, 36466, 36482, 36483)
- 2 deleted codes (36120 and 36515)
- 6 revised codes (36140, 36468, 36470, 36471, 36516, 36908)

Hemic and Lymphatic

- Bone Marrow or Stem Cell Services/Procedures:
 - 2 codes revised (38220, 38221), 1 code added (38222)
- Parenthetical notes added, revised, and deleted
- Code added (38573) and exclusionary parenthetical note

Endovascular Repair

- Renamed Endovascular Repair of Abdominal Aorta and/or Iliac Arteries
- Deleted codes: 34800–34806, 34825, 34826, 34900
- Added codes: 34701-34713, 34714, 34715, 34716
- Numerous guidelines and parenthetical notes added

Digestive

- Esophagus subsection:
 - 3 codes (43286, 43287, 43288) added to identify esophagectomy performed with a scope
 - 1 code (43112) revised
- Multiple parenthetical notes added and revised

Genital

- Male Genital System:
 - Code 55450 deleted due to low utilization
 - Code 55874 added for placement of biodegradable matter
- Female Genital System:
 - Codes (57240, 57260, 57265) revised to include cystourethroscopy
 - Code 58575 added to the Corpus Uteri subsection

Nervous

- Spine and Spinal Cord: definitions clarify use of partial corpectomy
- Neurorrhaphy With Nerve Graft, Vein Graft, or Conduit:
 - 2 new codes (64912, 64913) repair with nerve allograft

Revised:

76000, 76881, 76882

New:

- 71045 - 71048, 74018 - 74019, 74021
- G0202, G0204, G0206 will replace 77065, 77066, 77067, respectively

Deleted:

- 71010, 71015, 71020, 71021, 71022, 71023, 71030, 71034, 71035, 74000, 74010, 74020, 75952, 79563, 75954, 77442, 78190

Note:

- Four new codes for chest x-ray services specify only the number of views
- Nine view-specific chest x-ray codes deleted
- Views do not equal images! Views are discrete anatomic projections (e.g. AP, lateral, oblique)
- Multiple images may be needed to perform a complete view

Revised:

- 80305 - 80307, 81257, 81400, 81401, 81403-81406, 81432, 81439, 82043, 82044, 82044, 82042, 86003, 86005

New:

- 81175 - 81176, 81230 - 81232, 81238, 81247 - 81249
- 81258 - 81259, 81269, 81105 - 81112, 81120, 81121, 81283, 81334, 81328, 81335, 81346, 81361 - 81364, 81448, 81520, 81521, 81541, 81551, 86008, 86794, 87634, 87662
- 0001U - 0017U (*New code range – Proprietary Laboratory Analyses!!*)

Deleted:

- 83499, 84061, 86185, 86243, 86378, 86729, 86822, 87277, 87470, 87477, 87515, 88154

- 17 New codes
 - Describe proprietary clinical laboratory analyses cleared or approved by the Food and Drug Administration (FDA)
- PLA codes take precedence over the 80000 series codes for similar laboratory analyses
 - Do not report the service with any other CPT codes
 - Do not report other CPT codes for services that may be reported with a specific PLA code
- **Note:** Codes in this subsection are released on a quarterly basis to expedite dissemination for reporting. PLA codes will be published electronically on the AMA CPT[®] website ([www.ama-assn.org/practice-management/CPT[®]-pla-codes](http://www.ama-assn.org/practice-management/CPT[®]-pla-codes)), distributed via CPT[®] data files on a quarterly basis, and, at a minimum, made available in print annually in the CPT[®] codebook.

Revised:

- 90651, 90620, 90621, 94621, 97760, 97761

New:

- 90587, 90750, 90756, 90682, 93792, 93793, 94617 - 94618, 95249, 96573 - 96574, 97127, 97763

Deleted:

- 94620, 97762

Vaccines, Toxoids

- 3 codes added (15730, 15733, and 19294)
- 1 code deleted (15732)
- 1 code revised (17250)
- Multiple parenthetical note additions and revisions

Dialysis

- 1 new add-on code (20939) for bone marrow aspiration for bone grafting during spine surgery only
- 2 codes deleted (29582 and 29583)

Ophthalmology

- Sinus Endoscopy
 - 5 new codes (31241, 31253, 31257, 31259, 31298)
 - 3 codes revised (31254, 31255, and 31276)
- Larynx: code 31320 deleted due to low utilization
- Trachea and Bronchi: codes 31645 and 31646 revised
- Lungs and Pleura: code 32994 added and 32998 revised
- New guidelines, new and revised parenthetical notes

Cardiovascular

- New instructional parenthetical notes for catheterization and percutaneous transcatheter procedures
- New subsection: Home and Outpatient International Normalized Ratio (INR) Monitoring Services
 - New guidelines, instructional parenthetical notes, and two new codes (93792 and 93793) for home INR monitoring

Pulmonary

- New and revised parenthetical notes
- Code 94620 deleted and code 94621 revised to include measurements of ventilation and ECG recordings
- Two new codes have been added:
 - 94617 to identify exercise testing for bronchospasm
 - 94618 to identify pulmonary stress testing

Endocrinology

- New guidelines
- Two revised codes (95250 95249)
- New code (95249) added for patient-provided equipment

Photodynamic Therapy

- Guidelines added and parenthetical notes revised
- Code 96567 revised to include terms “with application and illumination” for activation of photosensitive drug(s)
- Two new codes (96573 and 96574) and new parenthetical notes

Orthotic Management

- Subsection title revised: “Orthotic Management and Training and Prosthetic Training”
- One new code (97763), one deleted code (97762), and two codes (97760, 97761) revised to include initial encounter

The following services can now be performed as telehealth:

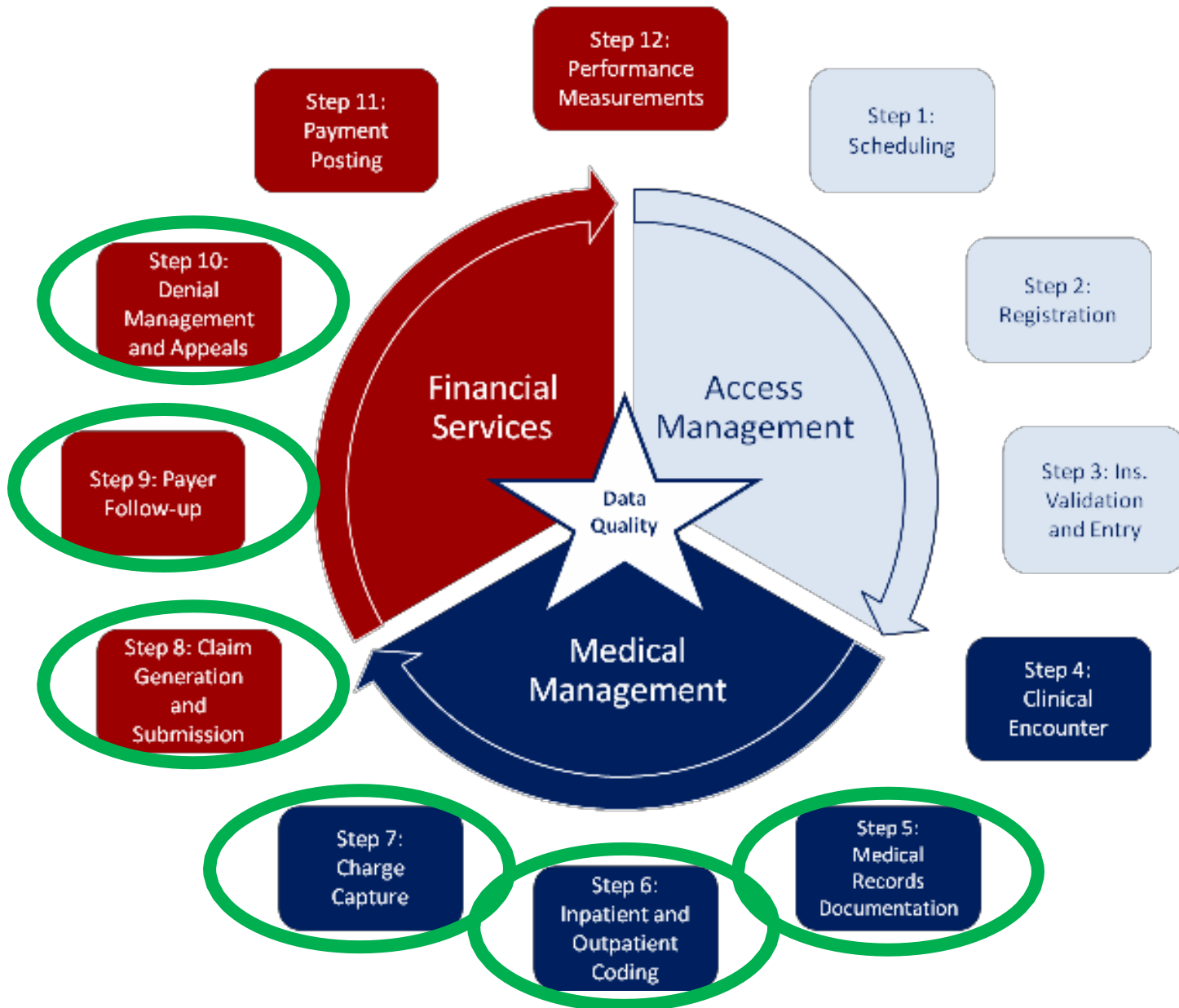
- HCPCS code **G0296** – *Counseling visit to determine low dose computed tomography (LDCT) eligibility*
- HCPCS code **G0506** – *Comprehensive assessment and care Planning for Chronic Care Management (list separately in addition to primary monthly care management service)*
- CPT® code **90785** - *Interactive Complexity (list separately in addition to the code for the primary procedure)*
- CPT® codes **90839 and 90840** - *Psychotherapy for Crisis, first 60 minutes and each additional 30 minutes (list separately in addition to code for primary procedure)*
- CPT® codes **96160 and 96161** – *Administration of patient-focused health Risk Assessment, with scoring/documentation, per standardized instrument*

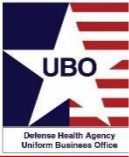
The following changes are now in effect for telehealth:

- Eliminate the required reporting of telehealth GT modifier for professional claims
- The use of the telehealth POS code 02 certifies that the service meets the telehealth requirements
- Addition of separate payment of 99091 - Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) ...transmitted to the physician minimum of 30 minutes...for remote patient monitoring

- Two new modifiers added:
 - 96 Habilitative Services
 - 97 Rehabilitative Services
- These new modifiers:
 - Identify the purpose of services as habilitative (to learn new skills) or rehabilitative (to restore or improve skills)
 - Reported with procedure or service codes that are habilitative or rehabilitative in nature (such as physical medicine and rehabilitation codes)
 - Enable the payer to differentiate between habilitative and rehabilitative services

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
- 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

Action Steps:

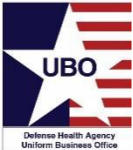
- Share CPT®/HCPCS changes and updates with all *relevant personnel*
- Providers *document patient encounter(s)*; pass the billable encounters on to coders -> billers -> third-party insurance companies -> pay patients -> other government agencies or other parties tortuously liable for the cost of the 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

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)

- 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

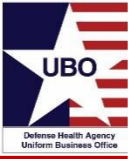
Help us to accurately determine your coverage. Please provide the following information.

I would like to search for a drug as a

Male Female age ▼

Search »

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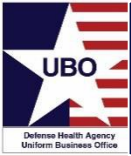
Denials from New, Revised and Deleted CPT®/HCPCS Codes - EOB (Explanation of Benefits)

- 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 %:** 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.



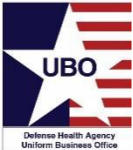


Denials from New, Revised and Deleted CPT®/HCPCS Codes - Tips for Tracking Denials

- 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
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- For further information: Denials Management Webinar
<http://health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/UBO-Learning-Center>

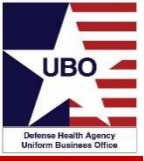


- If a new code is not listed in the DHA UBO Rate Table(s), how is a code added?
 - If you have a new code that is not in the applicable rate table send an e-mail to the UBO.Helpdesk@altarum.org with the specific code information and date of service in question. We will research whether there is or should be a rate for that code.
- If a patient's date of service was in CY 2017, but the claim is filed in CY 2018, 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 2018 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

- Changes in CPT®/HCPCS codes in 2018
- 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](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 NCR MD specific guidelines
- DHA UBO Helpdesk
 - [Email: UBO.Helpdesk@altarum.org](mailto:UBO.Helpdesk@altarum.org)
 - Phone: 202-741-1532

- American Medical Association: *Current Procedural Terminology (CPT®)2018*, Professional Edition, Chicago, 2017. The Association.
- Centers for Medicare & Medicaid Services, 2018 Healthcare Common Procedure Coding System (HCPCS).
www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.htm



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