NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

2015 CPT® Changes

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2015 CPT Changes

- 266 New Codes
- 147 Deleted Codes
- 129 Revised Codes

- Total of 9,951 CPT codes to master!

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Evaluation & Management

Chronic Care Management

- 99490 – at least 20 minutes

Complex Chronic Care Management

- 99487 – 60 minutes
- +99489 – each additional 30 minutes

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Evaluation & Management

- Chronic Care Management 99490
- "Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation / decompensation, or functional decline. Code 99490 is reported when, during the calendar month, at least 20 minutes of clinical staff time is spent in care management activities"

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Evaluation & Management

- Complex Chronic Care Management 99487
- The same criteria for CCM is required as well as establishment or substantial revision of the a comprehensive care plan; medical, functional and/or psychosocial problems requiring medical decision making of moderate or high complexity; and clinical staff care management series for at least 60 minutes, under the direction of a physician or other qualified health care professional
  - Each add't 30 minutes reported with add-on code 99489

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Evaluation & Management

- Recommend billing CCM and CCCM as soon as the time threshold has been met.
- Will only be paid once per month to one provider – first one with their claim in the door gets paid

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Advanced Care Planning

- **99497**
  - Advanced Care Planning – first 30 minutes
- **+99498**
  - Each additional 30 minutes

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Evaluation & Management

- Advanced Care Planning 99497
- "…explanation and discussion of advanced directives such as standard forms (with completion of forms, when performed) by the physician; first 30 minutes face-to-face with the patient, family member(s), and/or surrogate
  - Each additional 30 minutes use add-on code 99498

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Evaluation & Management

- Advanced Care Planning can be billed on the same day as other E/M services

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Musculoskeletal System

- Arthrocentesis codes 20600-20610 have been revised and expanded for cases using ultrasound guidance

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20600 Arthrocentesis, aspiration and/or injection; **small** joint or bursa

20604 with ultrasound guidance, with permanent recording and reporting

20604 Arthrocentesis, aspiration and/or injection; **intermediate** joint or bursa

20605 with ultrasound guidance, with permanent recording and reporting

20610 Arthrocentesis, aspiration and/or injection; **major** joint or bursa

20611 with ultrasound guidance, with permanent recording and reporting

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Permanent Record

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

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Musculoskeletal System

- 27279 Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
- ▲27280 Arthrodesis, open, sacroiliac joint, ~~(~~including obtaining bone graft~~)~~, including instrumentation, when performed

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Active Wound Care Management

- ▲ 97605 Negative pressure wound therapy (eg, vacuum assisted drainage collection) ~~including topical application(s)~~ utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
- ▲ 97606 total wound(s) surface area greater than 50 square centimeters

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Active Wound Care Management

- 97607 Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s) wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
- 97608 total wound(s) surface area greater than 50 square centimeters

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Cardiothoracic Surgery

- 34839 Physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time

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Cardiothoracic Surgery

- New guidelines have been added to indicate that "planning" includes the review of high resolution cross-sectional images (eg, computed tomography [CT], computed tomography angiography [CTA], magnetic resonance imaging [MRI] and the utilization of 3-D software for iterative modeling of the aorta and device in multiplanar views and center line of flow analysis.
- Time does not need to be continuous but physician must spent a minimum of 90 minutes

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Gastroenterology

Editorial change:

"with or without collection of specimen(s)"

Replaced by:

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

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Gastroenterology

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

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

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Gastroenterology

Modifier 53

- When performing a screening or diagnostic endoscopy 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 with modifier 53

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Gastroenterology

Modifier 52

- For therapeutic examinations that do not reach the cecum, report the appropriate therapeutic colonoscopy code with modifier 52
- Report flexible sigmoidoscopy for endoscopic examination during which the endoscope is not advanced beyond the splenic flexure

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Gastroenterology

New Medicare G codes for 2015 – how to report for MDCR pt

- If the code has not changed from 2014 to 2015
  - Physicians report the CPT code
  - CMS fees based on 2014 values
- If the code has changed from 2014 to 2015
  - Physicians report the G code
  - CMS fees based on the 2014 values
- If the code is new for 2015
  - Physicians report the CPT code
  - Not valued by CMS

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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)

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Gastroenterology

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

For use with the Cologuard test

Medicare coverage once every three years

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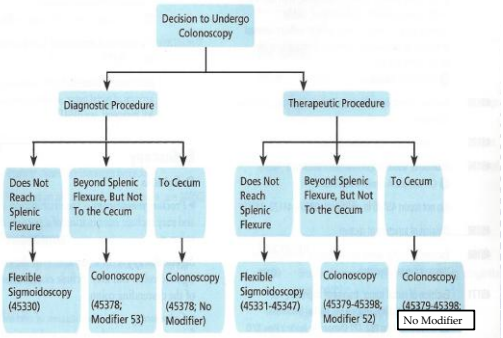
Colonoscopy Decision Tree



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Gastroenterology

- 0355T Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report

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Spinal Surgery

- 6 deleted codes
- 6 new codes
- New procedure codes are inclusive of bone biopsy when performed, moderate sedation, **and imagine guidance necessary to perform the procedure**.
- Use one primary code and an add-on code for additional levels.

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Spinal Surgery

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

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Spinal Surgery

- 22510 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
- 22511 lumbosacral
- + 22512 each additional cervicothoracic or lumbosacral vertebral body

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Spinal Surgery

- 22513 Percutaneous vertebral augmentation, including cavity creating (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic
- 22514 lumbar
- + 22515 each additional thoracic or lumbar vertebral body

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Drug Testing

The "Old" System

- Focused on qualitative versus quantitative testing
  - Qualitative: identified the family of the drug or narrowed the drug to certain classes. Used for screening (positive yes/no)
  - Quantitative: Identified specific analytes with a single code (how much)
- Drug Testing
- Therapeutic Drug Assays
- Chemistry

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Drug Testing

The "New" System

- New focus "Presumptive" versus "Definitive" testing
  - Allows for advances in medicine, number and type of materials tested, growth in specialty practices that directly deal with drug testing (such as Pain Medicine)
  - Allows identification of quantitative testing of multiple analytes within a single procedure
  - Methods for reporting analyte now more closely reflect effort needed to complete current methods for testing

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Drug Testing

New codes for Presumptive Drug Class Screening

- CPT lists drugs by class (A or B)
- Codes billed based off drug class tested and method
- Codes 80300-80304

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Drug Testing

New codes created for definitive drug testing

New Definitive Drug Class Listing added to CPT

Codes 80320-80377

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Ophthalmology

Changes to Glaucoma Filtration Device Codes

- 66179 Aqueous shunt to extraocular equatorial plate reservoir, external approach; **without graft**

▲ 66180 ~~Aqueous shunt to extraocular reservoir (eg, Molteno, Schocket, Denver Krupin)~~ **with graft**
(Do not report 66180 with 67255)

High percentage of shunts were done with scleral patch graft (67255) so code added/revised to reflect typical work

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Ophthalmology

- 66184 Revision of aqueous shunt to extraocular equatorial plate reservoir, external approach; **without graft**

▲ 66185 ~~Revision of aqueous shunt to extraocular reservoir~~ **with graft**
(Do not report 66185 with 67255)

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Ophthalmology

Vitrectomy codes found to be overvalued based on:

- Decreased physician time
- Post-operative complications/visits reduced

- Overall RVU reductions from 7% – 28% across code set 67036-67043

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Ophthalmology

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

Replaces category III code 0181T

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Ophthalmology

- 0356T Insertion of drug-eluting implant (including punctual dilation and implant removal when performed) into lacrimal canaliculus, each

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Cardiology

- Revisions to cardioverter defibrillator codes, changing "pacing cardioverter defibrillator" to "implantable defibrillator"
  (33215, 33216, 33217, 33218, 33220, 33223, 33224, 33225, 33240, 33230, 33231, 33241, 33262, 33263, 33264, 33243, 33244, 33249)
- New codes for subcutaneous defibrillator

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Cardiology

- 33270 Insertion/replacement of subcutaneous defibrillator system (pulse generator plus lead)
- 33271 Insertion of subcutaneous defibrillator electrode
- 33272 Removal of subcutaneous defibrillator electrode
- 33273 Repositioning of previous implanted electrode

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Cardiology

- 93260 Programming device evaluation, subcutaneous defibrillator system
- 93261 Interrogation device evaluation, subcutaneous defibrillator system
- 93644 Electrophysiologic evaluation, subcutaneous defibrillator system

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Cardiology

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

(Replace Category III codes 0343T and 0344T)

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Cardiology

- 93355 Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or greater vessel(s) structural intervention(s)…real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow and 3-D

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Cardiology

Do not report code 93355 with:	
Echocardiography	93312, 93313, 93314, 93315, 93316, 93317, 93318, 93320, 93321, 93325
3-D Image Reconstruction	76376, 76377

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Radiology

- Breast ultrasound code 76645 has been deleted, see now 76641, 76642
- 76641 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
- 76642 limited

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Radiology

- 76641 represents a complete ultrasound examination of the breast:
  - Examination of all four quadrants of the breast, and
  - The retroareolar region
- 76642 consists of a focused ultrasound examination of the breast:
  - Limited to the assessment of one or more quadrants but not all of the elements of the complete examination

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Radiology

- Breast Tomosynthesis
  - New codes for 2015 for breast tomosynthesis
  - New add-on code for screening digital breast tomosynthesis
- Creates a 3-D image of the breast(s) using X-rays

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Radiology

- 77061 Digital breast tomosynthesis; unilateral
- 77062 bilateral
- +77063 Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)

(Use 77063 in conjunction with 77057)

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Radiology

- CMS will recognize code 77063 to be reported when tomosynthesis is used in additional to 2-D mammography, as this service does not have an equivalent 2014 code
- CMS created G2079 (Diagnostic digital breast tomosynthesis, unilateral or bilateral – list separately in addition to G0204 or G0206)

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Radiology

77080 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg hips, pelvis, spine)

77081 appendicular skeleton (peripheral) (eg, radius, wrist, heel)

~~77082 vertebral fracture assessment~~

- 77085 axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment
- 77086 vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)

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Radiation Oncology

9 Deleted	3 Remaining but Modified
77403 77404 77406	77402 Radiation treatment delivery, >1 MeV; simple
77408 77409 77410	77402 Radiation treatment delivery, >1 MeV; intermediate
77413 77414 77416	77402 Radiation treatment delivery, >1 MeV; complex

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Radiation Oncology

SIMPLE

All of the following criteria are met (and one of the complex or intermediate criteria are met); single treatment area, one or two ports, and two or fewer simple blocks.

INTERMEDIATE

Any of the following criteria are met (and one of the complex criteria are met); 2 separate treatment areas, 3 or more ports on a single treatment area, or 3 or more simple blocks.

COMPLEX

Any of the following criteria are met; 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, field-in-field or other tissue compensation that does not meet IMRT guidelines, or electron beam.

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Radiation Oncology

3 Codes Deleted	1 New Code
77421 Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy	**77387** Guidance for localization of target volume for delivery of radiation treatment delivery, includes intra-fraction tracking, when performed
76950 Ultrasonic guidance for placement of radiation therapy fields	
0197T Intra-fraction localization and tracking of target or patient motion during delivery or radiation therapy	
1 Code No Longer Reported with Image Guided Radiation Therapy (IGRT)	
77014 Computed tomography guidance for placement of radiation therapy fields	

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Intensity Modulated Radiation Therapy (IMRT)

2 Codes Deleted	2 New Codes
77418 Intensity modulated treatment delivery	77385 IMRT delivery, includes guidance and tracking, when performed; simple
0073T Compensator based IMRT	77386 IMRT delivery, includes guidance and tracking, when performed; complex

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Intensity Modulated Radiation Therapy (IMRT)

SIMPLE
Any of the following: prostate, breast, and all sites using physical compensator based IMRT

COMPLEX
Includes all other sites if not using physical compensator based IMRT

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Radiation Oncology

- CMS delaying implementation of changes until 2016 due substantial nature of code revisions
- New and revised 2015 codes for Radiation Therapy codes (76950, 77014, 77421, 77387, 77401, 77402, 77403, 77404, 77406, 77407, 77408, 77409, 77411, 77412, 77413, 77414, 77416, 77418, 77385, ,77386, 0073T, 0197T) will not be recognized by Medicare in 2015
- CMS created G codes for use in 2015

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Radiation Oncology

2014 Code	2015 HCPCS
76950	G6001
77421	G6002
77402	G6003
77403	G6004
77404	G6005
77406	G6006
77407	G6007
77408	G6008
77409	G6009

2014 Code	2015 HCPCS
77411	G6010
77412	G6011
77413	G6012
77414	G6013
77416	G6014
77418	G6015
0073T	G6016
0197T	G6017

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Teletherapy Isodose Planning

3 Codes Deleted	2 New Codes
77305 Teletherapy isodose plan; simple	77306 Teletherapy isodose plan; simple
77310 Teletherapy isodose plan; intermediate	77307 Teletherapy isodose plan; complex
77315 Teletherapy isodose plan; complex	Do not report 77300 with these codes

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Brachytherapy Isodose Planning

3 Codes Deleted	3 New Codes
77326 Brachytherapy isodose plan; simple	77316 Brachytherapy isodose plan; simple
77327 Brachytherapy isodose plan; intermediate	77317 Brachytherapy isodose plan; intermediate
77328 Brachytherapy isodose plan; complex	77318 Brachytherapy isodose plan; complex

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Pediatrics / Family Medicine

- 90651 Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58 nonavalant (HPV), 3 dose schedule for intramuscular use
- 90630 Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
- ▲ 90654 Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use

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Pediatrics / Family Medicine

▲ 96110 Developmental screening (eg, developmental milestone survey, speech and language delay screen) with scoring and documentation, per standardized instrument

(For an emotional/behavioral assessment, use 96127)

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Pediatrics / Family Medicine

- 96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

(For developmental screening, use 96110)

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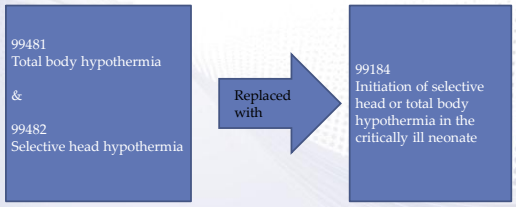
Hypothermia of Neonates



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Hypothermia of Neonates

Code 99184 combines both selective head and total body hypothermia of neonates into a single description that includes all of the service components required of this procedure, including:

- The review of clinical, imaging and laboratory data
- Confirmation of esophageal temperature probe location
- Evaluation of amplitude electroencephalography (EEG)
- Supervision of controlled hypothermia
- Assessment of patient tolerance of cooling

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Hypothermia of Neonates

- With no E/M service in this code, the hypothermia services are located in the Medicine section
- Code 99184 represents a single service that may be reported only once per hospital stay, as captured in the parenthetical note following code 99184
- Hypothermia services are considered a separately reported service from the initial inpatient and subsequent inpatient neonatal critical care codes 99468 and 99469

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Pediatrics / Family Medicine

- 99188 Application of topical fluoride varnish by a physician or other qualified health care professional

Cannot be reported if performed by ancillary staff
CMS will not cover

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References

- AMA 2015 CPT® Professional
- AMA CPT® Changes 2015: An Insider's View
- AMA CPT® and RBRVS 2015 Annual Symposium
- NAMAS Coding Revolution
- CMS 2015 Proposed Physician Fee Schedule

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