Defense Health Agency
Uniform Business Office

2020 CPT®/HCPCS Updates and Impact on Billing

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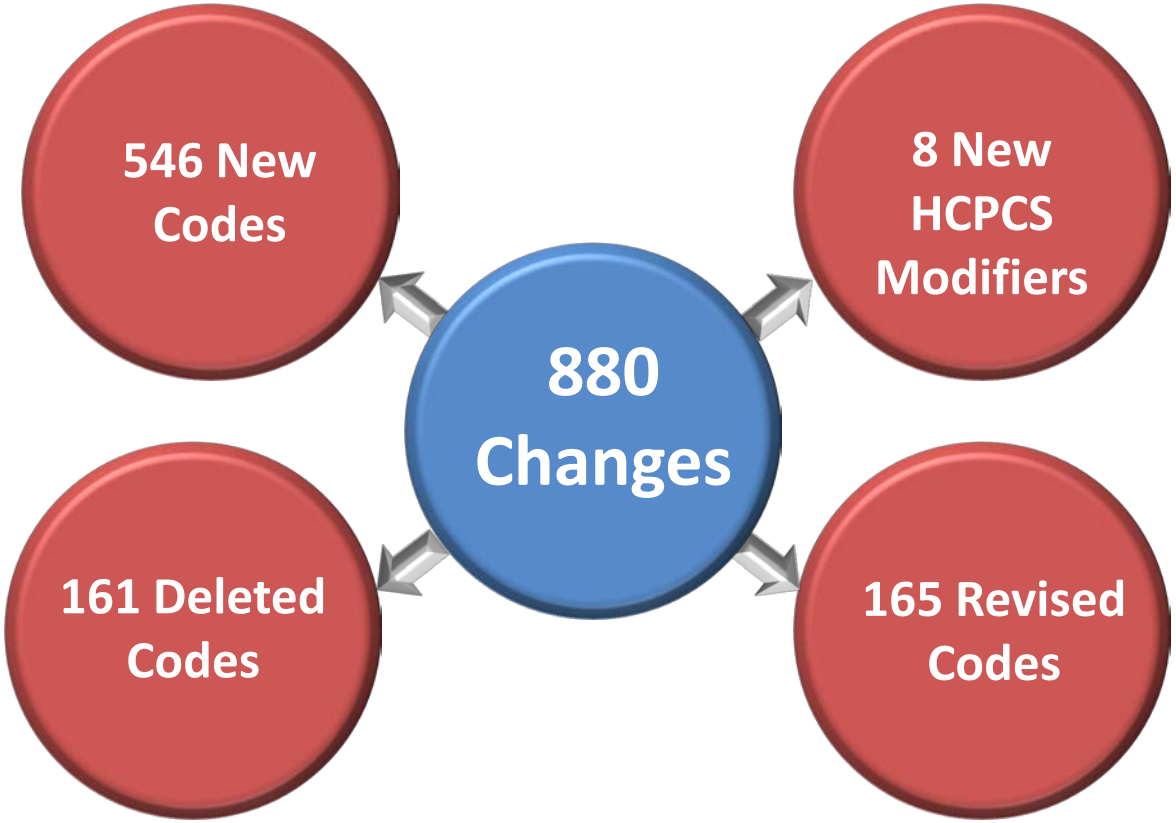
Agenda

- Changes to Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) Codes
- Effective Dates and Symbols for 2020 CPT® Code Changes
- Proposed Action for Code Changes
- Overview of the new, revised, and deleted 2020 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 800 code changes. Changes to CPT®/ HCPCS are effective January 1st, 2020



Effective Dates

- 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 2020 CPT®/HCPCS codes *generally effective 1 July*
  - For the DHA UBO Outpatient 2020 ***NEW*** codes, rates are 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 2020 once loaded into ABACUS
  - DHA UBO rates cannot be applied retroactively

Symbols for 2020 CPT® Code Changes

● **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

Category I PLA symbol - indicates a Category I PLA

Proposed Action for Code Changes Coding and Billing Personnel

Coding Department Supervisors:

- Order 2020 codebooks
- Archive previous year manuals

Coders:

- Review 2020 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)

Proposed Action for Code Changes, Cont.

Clinical Documentation Improvement (CDI) Specialists:

- Create a documentation 'cheat sheet' of 2020 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 2020 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 2020 updates

Billing Personnel:

- Review new payer policy changes that pertain to the 2020 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 2020 CPT®/HCPCS Codes

CPT Level I and Category III Codes

Revised:

- 31233, 31235, 31292-31298, 33275, 35701, 46945, 46946, 54640, 62270, 62272, 64400, 64405, 64408, 64415-64418, 64420, 64421, 64425, 64430, 64435, 64445-64450, 66711, 66982, 66984, 74022, 74210, 74220, 74230, 74240, 74246, 74250, 74251, 74270, 74280, 78459, 78491, 78492, 78800-78804, 81350, 81404, 81406,81407, 008U, 90734, 92548, 92626, 92627, 93784, 93786, 93788, 93790, 94728, 95813, 99457, 0402T

New:

- 15769, 15771-15574, 20560,20561, 20700-20705, 21601-21603, 33016-33019, 33858, 33859, 33871, 34717, 34718, 35702, 35703, 46948, 49013, 49014, 62328, 62329, 64451, 64454, 64624, 64625, 66987, 66988, 74221, 74248, 78429-78434, 78830-78832, 78835, 80145, 80187, 80230, 80235, 81277, 80280, 80285, 81307-81309, 81522, 81542, 81552, 87563, 0062U-0080U, 0082U-0103U, 0105U-0138U, 90619, 90694, 90912, 90913, 92201, 92202, 92549, 93356, 93985, 93986, 95700, 95705-95726, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, 97129, 97130, 98970-98972, 99421, 99422, 99423, 99473,99474, 99458, 0543T-0593T

Deleted:

- 19260, 19271, 19272, 19304, 20926, 33010, 33011, 33015, 33860, 33870, 35721, 35741, 35761, 43401, 64402, 64410, 64413, 74241, 74245, 74249, 74260, 76930, 78205, 78206, 78320, 78607, 78647, 78710, 78805-78807, 0020U, 0028U, 0057U, 0081U, 0104U, 90911, 92225, 92226, 93299, 95827, 95831-95834, 95950, 95951, 95953, 95956, 96150-96155, 97127, 98969, 99444, 0205T, 0206T, 0249T, 0254T, 0341T, 0357T, 0375T, 0377T, 0380T, 0399T, 0482T

Evaluation and Management (E/M)

Revised:

- 99457
  - Remote physiologic monitoring treatment management services; interactive communication (99457) guidelines and code revised to report the first 20 minutes of service.

New:

- 99421, 99422, 99423, 99473,99474, 99458
  - Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days (99421-99423)
  - Used to report self-measured blood pressure monitoring using a device validated for clinical accuracy (99473 and 99474)
  - Add-on code used to report each additional 20 minutes of remote physiologic monitoring treatment management services (99458)

Deleted:

- 99444

Integumentary

- 5 new codes (15769, 15771-15774) to report autologous soft tissue and fat grafting
- 4 codes deleted (19260, 19271, 19272) renumbered and relocated; 19304 low utilization)

Musculoskeletal

- General:
  - 8 new codes: (20560, 20561) identify needle insertion without injection; (20700-20705) report insertion and removal of drug-delivery devices
  - 1 code deleted (20926)
- Neck: 3 new codes (21601-21603) replace 19260, 19271, 19272

Respiratory

- Accessory Sinuses: 9 revised codes (31233, 31235, 31292-31298)

Cardiovascular

- Heart and Pericardium:
  - 7 new codes (33016-33019, 33858, 33859, 33871)
  - 1 code revised (33275)
  - 3 deleted codes (33010, 33011, 333015)
- Arteries and Veins
  - 4 new codes (34717, 34718, 35702, 35703)
  - 1 revised code (35701)
  - 5 deleted codes (33860, 33870, 35721, 35741, 35761)

Digestive

- Esophagus
  - 1 deleted code (43401)
- Anus:
  - 1 new code (46948)
  - 2 revised codes (46945, 46946
- Abdomen, Peritoneum, and Omentum
  - 2 new codes (49013, 49014)

Male Genital

- 1 revised code (54640)

Nervous

- Spine and Spinal Cord:
  - 2 new codes (62328, 62329)
  - 2 revised codes (62270, 62272)
- Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System:
  - 4 new codes (64451, 64454, 64624 64625)
  - 18 revised codes (64400-64450)
  - 3 deleted codes (64402, 64410, 64413)

Eye and Ocular Adnexa

- Anterior Segment:
  - 2 new codes (66987, 66988)
  - 3 revised codes (66711, 66982, 66984)

Revised:

- 74022, 74210, 74220, 74230, 74240, 74246, 74250, 74251, 74270, 74280, 78459, 78491, 78492, 78800-78804

New:

- 74221, 74248, 78429-78434, 78830-78832, 78835

Deleted:

- 74241, 74245, 74249, 74260, 76930, 78205, 78206, 78320, 78607, 78647, 78710, 78805-78807

Note:

- Revisions to Diagnostic Radiology, Gastrointestinal tract subsection include the revision of nine codes to reflect current practice, deletion of five codes whose services are captured in revised codes and the addition of two codes.
- Radiology nuclear medicine subsection changes to better provide radiopharmaceutical localization of tumors through planar or by tomographic (SPECT) technique. Changes include the addition of 78830-7832 to report tomographic (SPECT) studies and (78835) for radiopharmaceutical quantification measurement(s), deletion of 78805-78807, and revision of 78800-78804

Revised:

- 81350, 81404, 81406, 81407, 008U

New:

- 80145, 80187, 80230, 80235, 81277, 80280, 80285, 81307-81309, 81522, 81542,81552, 87563
- 0062U-0080U, 0082U-0103U, 0105U-0138U

Deleted:

- 0020U, 0028U, 0057U, 0081U, 0104U,

Note:

Guidelines in the Proprietary Laboratory Analyses subsection have been revised to explain the new PLA symbol ⬆⬇

Pathology and Laboratory

- 89 New codes
  - 6 new Therapeutic Drug Assays codes
  - 4 new tier 1 molecular pathology codes (81277, 81307-8109) and 1 revised (81350)
  - 3 revised tier 2 molecular pathology codes (81404, 81406, 81407)
  - 75 new PLA codes
    - 5 codes deleted: 00202U, 0028U, 0057U, 0081U, and 0104U
    - 1 revision: 0008U to report H. pylori and antibiotic resistance detection
  - 3 Cat 1 Multianalyte Assays with Algorithmic Analyses (MAAA) codes (81522, 81542, 81552)
  - 1 new microbiology code

Revised:

- 90734, 92548, 92626, 92627, 93784, 93786, 93788, 93790, 94728, 95813

New:

- 90619, 90694, 90912, 90913, 92201, 92202, 92459, 93356, 93985, 93986, 95700, 95705-95726, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, 97129, 97130, 98970-98972

Deleted:

- 90911, 92225, 92226, 93299, 95827, 95831-95834, 95950, 95951, 95953, 95956, 96150-96155, 97127, 98969

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

- 2 new code pending FDA approval
  - (90694) a new quadrivalent influenza vaccine, (90619) a meningococcal conjugate vaccine using a tetanus-toxoid carrier
- 1 revised code (90734) to include language for code 90619.

Biofeedback

- 2 new codes (90912, 90913)
- 1 deleted code (90911) replaced by codes 90912 and 90913

Ophthalmology

- 2 new codes (922201, 92202)
- 2 deleted codes (92225 and 92226)

Special Otorhinolaryngologic Services

- 1 new code (92549) for CDP-SOT performed with a motor control and adaptation test.
- 3 revised codes (92548, 92626, 92627)

Cardiovascular

- 4 revised codes (93784, 93786, 93788, 93790) revised to include report-generating, automated software worn continuously.
- 1 deleted code (93299)

Noninvasive Vascular Diagnostic Studies

- Extremity Arterial-Venous Studies: 2 new codes (93985, 93986)
  - Report complete bilateral and unilateral duplex scan of study of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access

Pulmonary

- Pulmonary Diagnostic Testing and Therapies: 1 revised codes (94728)
  - Removes term “impulse”

Neurology and Neuromuscular Procedures

- Routine Electroencephalography
  - 1 revised code (95813)
  - 1 deleted code (95827)
- Range of Motion Testing
  - Heading changed with the removal of the reference to muscle testing. (Formerly Muscle and Range of Motion Testing
  - 4 deleted codes (95831-95834)
- Special EEG Testing
    - 23 new codes: 2 new subsections have been added and new guidelines added including new definitions and a long-term EEG monitoring table.
      - Long-Term EEG Setup (95700)
      - Monitoring; TC Services (95705-95716) and professional component (PC) (95717-95726)
    - 4 deleted codes (95950,95951, 95953, 95956)

Health Behavior Assessment and Intervention

- 9 new codes (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171)
- 6 deleted codes (96150-96155)
- Additional guidelines added to describe difference between assessment and interventions.

Physical Medicine and Rehabilitation

- 2 new codes (97129, 97130) to report therapeutic interventions that focus on cognitive function.
- 1 deleted code (97127)

Non-Face-to Face Nonphysician Services

- 3 new codes (98970-98972)
- 1 deleted code (98969)
- Addition of new subsection Qualified Nonphysician Health Care Professional Online Digital Evaluation and Management Service, with new guidelines.

HCPCS Modifiers

- **HCPCS modifiers added:**

- **MA:** Ordering professional is not required to consult a clinical decision support mechanism due to service being rendered to a patient with a suspected or confirmed emergency medical condition
- **MB**: Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access
- **MC**: Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of electronic health record or clinical decision support mechanism vendor issues
- **MD:** Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of extreme and uncontrollable circumstances
- **ME:** The order for this service adheres to appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
- **MF:** The order for this service does not adhere to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
- **MG:** The order for this service does not have applicable appropriate use criteria in the qualified clinical decision support mechanism consulted by the ordering professional
- **MH:** Unknown if ordering professional consulted a clinical decision support mechanism for this service, related information was not provided to the furnishing professional or provider

Note: Appropriate use criteria includes Advanced Radiology Procedures – 70010-79999, C1713-C8937, Q5101-Q9992, and S0012-S9999.

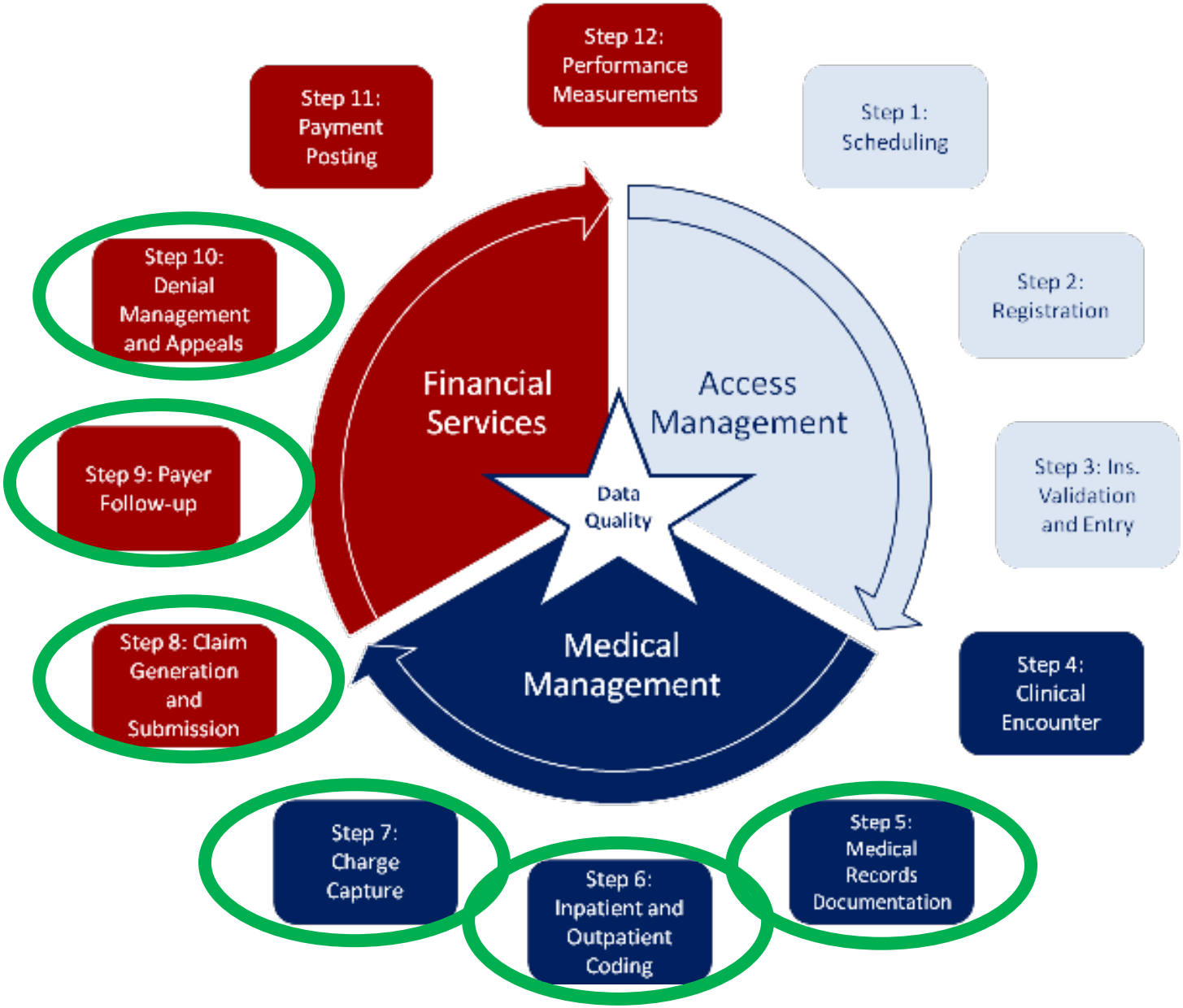
▲ **Revised modifiers:**

- **50:** guidelines revised with instructions for reporting add-on procedures that are performed bilaterally. Add-on codes for bilateral procedures to be reported twice instead of reporting modifier 50.
- **63:** Codes in the definition of modifier 63 have been revised to include services from the Medicine/ Cardiovascular section. The revised descriptor now includes codes 92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312-93318, 93452, 93505, 93530-93532, 93561-93564, 93568, 93580, 93582, 93590-93592, 93615, and 93616

Summary of CPT Codes Exempt from Modifier 51:

- 20697, 20974, 20975, 44500, 61107, 93600, 93602, 93603, 93610, 93612, 93615, 93616, 93618, 94610, 95905, 99151, 99152

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

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

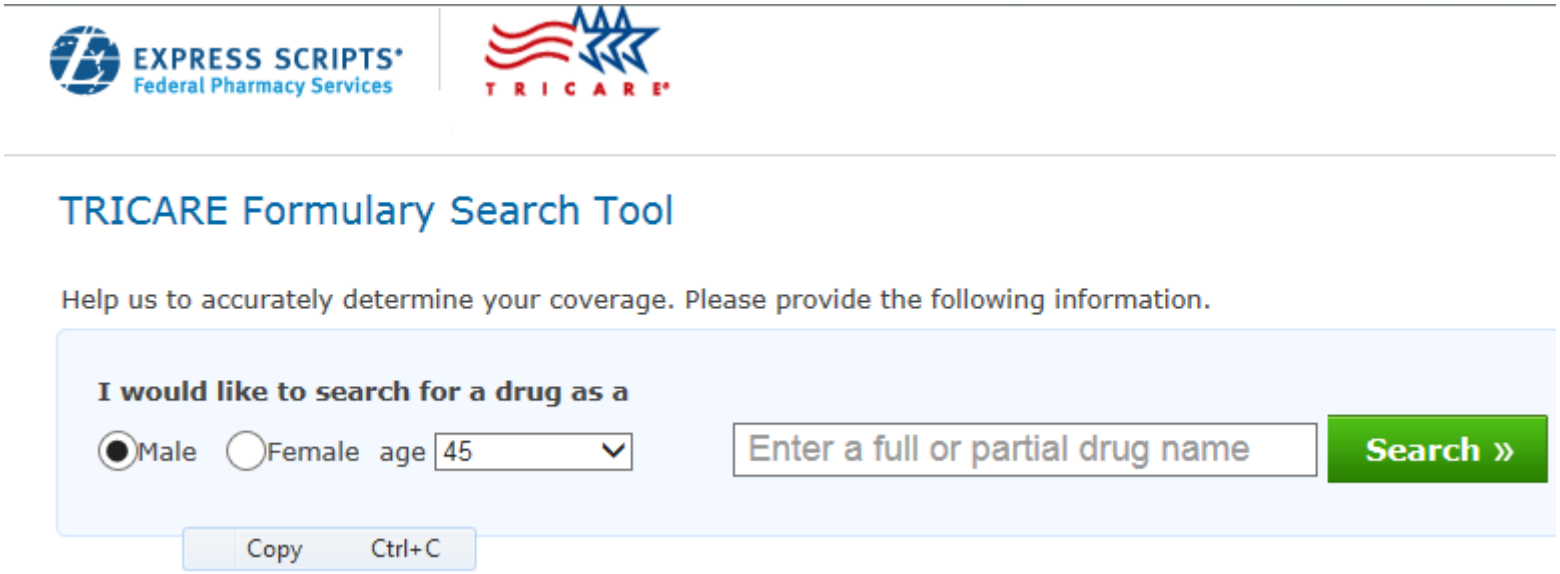
- Each line item must match medical coding data
- "Bundling" may lead to denials in EOBs
  - Refers to coding related medical services as one inclusive procedure, in contrast to submitting claims for separate services
- Individual MTF UBOs are not authorized to make coding changes
  - If claim is denied 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@IntellectSolutions.com)

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]

Billing for New and Revised NDC Codes – Prior Authorizations

- 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



- 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@IntellectSolutions.com 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 2019, but the claim is filed in CY 2020, 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 2020 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 is the out of cycle update for CMAC codes from the new 2020 CPT/HCPCS release, effective January 1, 2020
  - 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

Wrap-Up

- Changes in CPT®/HCPCS codes in 2020
- 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

Resources

- 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 specific guidelines
- DHA UBO Helpdesk
  - Email: UBO.Helpdesk@IntellectSolutions.com

References

- American Medical Association: *Current Procedural Terminology (CPT®)*2020, Professional Edition, Chicago, 2019.
- Centers for Medicare & Medicaid Services, 2020 Healthcare Common Procedure Coding System (HCPCS). www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.html

Thank You

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  - E-mail answers to UBO.LearningCenter@IntellectSolutions.com
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