FYI:

Review of CDM Code Changes Effective Jan. 2018

AMA updates CPT codes annually, effective January 1 of each year. CMS updates HCPCS quarterly, with major updates also effective every January 1.

CDM Coordinators must understand the code changes thoroughly, including deleted codes and replacement codes as well as revised codes. Revisions may represent significant change in the intent of CPTs and HCPCS, as well as units applicable per reportable code. The financial implications of combined codes and changes to reportable units must be conveyed to departments and to Finance annually.

Revenue Cycle Analysts must coordinate a team including Managers, HIM, Coding, Billing and others to ensure that all updates are accurate and consistent and that they maximize revenue and reimbursement efforts.

Downstream, costly billing errors persist even where timely and accurate CDM reviews are performed. Each EMR and billing system uses exclusive tools and language to describe processes, so care must be taken to ensure that everyone has the same interpretation regarding changes. Orders may continue to reflect deleted codes or deleted code descriptions. Order Sets, Order Entry, Templates, Preference Lists, Smart Sets, Smart Phrases, SOAP notes, and any other tools used to guide documentation and charging for services must be reviewed and corrected. Education must also be provided to servicing departments, and charge mechanisms must be updated to ensure accuracy. Paper charge sheets, templates, end-of-exam rules and Order Entry processes must be reviewed and updated where necessary. CDM Coordinators and Revenue Analysts must:

1. Read and thoroughly understand the code changes and details provided
2. Schedule meetings with billing, providers, HIM and coders to review changes and gain feedback on proper replacement codes and likely combination of codes
3. Identify all internal processes impacted by changes and coordinate necessary updates
4. Convey changes in descriptions and units to Finance
5. Obtain fees for new charge codes that combine separately reportable services
6. Update encounters and chargemaster
7. Communicate both CDM and process change requirements to billers, coders and departments
8. Follow up with a review within one month of change implementation to ensure that orders, templates, rules, and other documentation requiring change have been updated
9. Sign off on education updates and CDM completion

NEW CODES

One hundred fifty-five new CPTs and 141 HCPCS have been created for 2018. Codes specifically created to replace the deleted codes are detailed below. The chargemaster should be reviewed to identify deleted codes and replacement codes should be determined. Departments should be included in discussions to ensure that proper replacement codes are created. Where applicable, orders, order entry, charge encounter sheets and processes for Medical Necessity should be updated. Education must be provided to ensure proper reporting. New codes that do not specifically replace active CDM codes should not be added to the Charge Data Master until the service recognized by the new CPT is provided. New code additions should always be vetted by Coding to ensure proper and compliant code assignment.

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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DELETED EFFECTIVE 1/1/2018

One hundred and twenty CPTs and HCPCS were deleted effective January 1, 2018. Deleted codes should be identified and replacements determined. Departments should be included in discussions to ensure that proper replacement codes are created. Where applicable, orders, order entry, charge encounter sheets and processes for Medical Necessity should be updated. Education must be provided to ensure proper reporting.

DRUG CODE CHANGES

Thirty-eight temporary drug codes will be replaced with more permanent J-codes.

One drug changed twice in 2017. C9487 was replaced with Q9989 in July 2017, and Q9989 will be deleted and replaced with J3358. Chargemasters must be updated and utilization reviewed to ensure that the mid-year change was properly updated.

Two drug code changes represented a change in reportable units. Chargemasters, including any background multiplier, must be updated, along with paper charge sheets. Departments responsible for ordering and reporting units must be educated.

HCPCS	CMS Short Description	Replacement	Suggested Description	Action
J1725	Hydroxyprogesterone caproate 1 mg	J1729	RX HYDROXYPROGESTERONE CAPROATE, NOS 10 MG	Units changed from 1 mg to per 10 mg
J9300	Gemtuzumab ozogamicin inj 5mg	J9203	RX GEMTUZUMAB OZOGAMICIN, 0.1 MG	Units changed from 5 mg to .1 mg

Thirteen drug codes will be deleted and replaced with more permanent J-codes, with no unit change. Chargemasters and order entry must be reviewed and corrected. Providers, departments, coders and billers must be educated.

Drug Code Changes

HCPCS	CMS Short Description	Suggested Replacement	Suggested Description
C9140	Afstyla factor viii recomb 1 IU	See: J7210	RX Factor VIII AFSTYLA 1 IU
C9483	Injection, atezolizumab	See: J9022	RX ATEZOLIZUMAB, 10 MG
C9484	Injection, eteplirsen 10 mg	See: J1428	RX ETEPLIRSEN, 10 MG
C9485	Injection, olaratumab	See: J9285	RX OLARATUMAB, 10 MG
C9486	Inj, granisetron ext	See: J1627	RX GRANISETRON, EXTENDED-RELEASE, 0.1 MG
C9489	Injection, nusinersen	See: J2326	RX NUSINERSEN, 0.1 MG
C9490	Injection, bezlotoxumab	See: J0565	RX BEZLOTOXUMAB, 10 MG
C9491	Injection, avelumab	See: J9023	RX AVELUMAB, 10 MG
C9494	Injection, ocrelizumab	See: J2350	RX OCRELIZUMAB, 1 MG
Q9984	Kyleena, 19.5 mg	See: J7296	RX LEVONORGESTREL IU CONTRACEPTIVE SYSTEM, KYLEENA 19.5 MG
Q9985	Inj hydroxyprogst capoat nos	J1729	RX HYDROXYPROGESTERONE CAPROATE, NOT OTHERWISE SPECIFIED, 10 MG

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

Drug Code Changes

HCPCS	CMS Short Description	Suggested Replacement	Suggested Description
Q9986	Makena, 10 mg	J1726	RX HYDROXYPROGESTERONE CAPROATE, (MAKENA), 10 MG
Q9989	Ustekinumab, iv inject,1 mg	J3357	RX USTEKINUMAB, SUBCU INJECTION, 1 MG

RADIOLOGY CODE CHANGES

Radiology changes include removing location designations for chest x-rays and abdominal x-rays, inclusion of radiology components into surgical procedures, and deletion of one radiopharmaceutical code. Medicare will accept CPT for mammograms in 2018, and associated HCPCS have been deleted. Radiology code changes represent high-volume services. Delays or errors in the update process may drive significant delay in charges and payment while also generating significant rework. Services impacted will require orders, so care must be taken to update orders and order entry process, and to educate ordering providers, coders and billers.

Radiology Code Changes

HCPCS	CMS Short Description	Suggested Replacement	Suggested Description	Action
G0202	Scr mammo bi incl cad	77067	SCREENING MAMMOGRAPHY INC CAD BILATERAL	HCPCS was deleted for 2018. Medicare is accepting CPT.
G0204	Dx mammo incl cad bi	77066	DX MAMMOGRAPHY INC CAD BILATERAL	HCPCS was deleted for 2018. Medicare is accepting CPT.
G0206	Dx mammo incl cad uni	77065	DX MAMMOGRAPHY INC CAD UNLATERAL	HCPCS was deleted for 2018. Medicare is accepting CPT.
71010	Chest x-ray 1 view frontal	71045	CHEST X-RAY SINGLE VIEW	New Chest x-ray codes combine positions and specify number of views.
71015	Chest x-ray stereo frontal	71045	CHEST X-RAY SINGLE VIEW	New Chest x-ray codes combine positions and specify number of views.
71020	Chest x-ray 2vw frontal&latl	71046	CHEST X-RAY 2 VIEWS	New Chest x-ray codes combine positions and specify number of views.
71021	Chest x-ray frnt lat lordotc	71047	CHEST X-RAY 3 VIEWS	New Chest x-ray codes combine positions and specify number of views.
71022	Chest x-ray frnt lat oblique	71047-71048		New Chest x-ray codes combine positions and specify number of views.
71023	Chest x-ray and fluoroscopy	71046, 76000-76001		New Chest x-ray codes combine positions and specify number of views.
71030	Chest x-ray 4/> views	71048	CHEST X-RAY 4 OR MORE VIEWS	New Chest x-ray codes combine positions and specify number of views.

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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Radiology Code Changes

HCPCS	CMS Short Description	Suggested Replacement	Suggested Description	Action
71034	Chest x-ray&fluoro 4/> views	71048, 76000-76001		New Chest x-ray codes combine positions and specify number of views.
71035	Chest x-ray special views	71046-71048		New Chest x-ray codes combine positions and specify number of views.
74000	X-ray exam of abdomen	74018	ABDOMINAL XRAY 1 VIEW	New abdominal X-ray CPTS combine locations and specify number of views.
74010	X-ray exam of abdomen	74019, 74021		New abdominal X-ray CPTS combine locations and specify number of views.
74020	X-ray exam of abdomen	74019, 74021		New abdominal X-ray CPTS combine locations and specify number of views.
75658	Artery x-rays arm	75710		
75952	Endovasc repair abdom aorta	34701-34706, 34709-34711		CPT 34701-34711 includes procedure and Radiological supervision and interpretation.
75953	Abdom aneurysm endovas rpr	34709-34711		CPT 34701-34711 includes procedure and Radiological supervision and interpretation.
75954	Iliac aneurysm endovas rpr	34703-34711		CPT 34701-34711 includes procedure and Radiological supervision and interpretation.
77422	Neutron beam tx simple			
78190	Platelet survival kinetics			
A9599	Radioph dx b amyloid pet nos			

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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NEW TECHNOLOGY CODE DELETIONS

Twenty-two New Technology (T-Codes) will be retired, and many replaced by unlisted procedure codes or codes representing services "Not Otherwise Specified." Payors usually require medical records to price unlisted codes. Billers and coders should be educated and prepared. Providers should be notified where applicable.

New Technology Code Deletions

HCPCS	CMS Short Description	Suggested Replacement	Replacement Long Description
0051T	Implant total heart system	33928-33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)
0052T	Replace thrc unit hrt syst	33928-33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)
0053T	Replace implantable hrt syst	33928-33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)
0178T	64 lead ecg w/i&r	93799	Unlisted cardiovascular service or procedure
0179T	64 lead ecg w/tracing	93799	Unlisted cardiovascular service or procedure
0180T	64 lead ecg w/i&r only	93799	Unlisted cardiovascular service or procedure
0255T	Evasc rpr iliac art bifr s&i	0254T	Endovascular repair of iliac artery bifurcation (e.g., aneurysm, pseudoaneurysm, arteriovenous malformation, trauma, dissection) using bifurcated endograft from the common iliac artery into both the external and internal iliac artery, including all selective and/or nonselective catheterization(s) required for device placement and all associated radiological supervision and interpretation, unilateral
0293T	Ins lt atrl press monitor		
0294T	Ins lt atrl mont pres lead		
0299T	Esw wound healing init wound		
0300T	Esw wound healing addl wound		
0301T	Mw therapy for breast tumor		
0302T	Icar ischm mntrng sys compl		
0303T	Icar ischm mntrng sys eltrd		

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

New Technology Code Deletions

HCPCS	CMS Short Description	Suggested Replacement	Replacement Long Description
0304T	Icar ischm mntrng sys device		
0305T	Icar ischm mntrng prgrm eval		
0306T	Icar ischm mntr interr eval		
0307T	Rmvl icar ischm mntrng dvce		
0309T	Prescrl fuse w/ instr l4/l5	22899	Unlisted procedure, spine
0310T	Motor function mapping ntms	64999	Unlisted procedure, nervous system
0340T	Ablate pulm tumors + extnsn	32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation
0438T	Tprnl plmt biodegrdabl matrl	55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed

LAB CODE DELETIONS

Twelve lab codes will be deleted, with no specific replacement codes. Review method and constituent options available. Review all orders, including order sets, and order preferences, and update accordingly.

HCPCS	CMS Short Description
83499	Assay of progesterone 20-
84061	Phosphatase forensic exam
86185	Counterimmunoelectrophoresis
86243	Fc receptor
86378	Migration inhibitory factor
86729	Lympho venereum antibody
86822	Lymphocyte culture primed
87277	Legionella micdadei ag if
87470	Bartonella dna dir probe
87477	Lyme dis dna quant
87515	Hepatitis b dna dir probe
88154	Cytopath c/v select

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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BLOOD BANK DELETIONS

Three blood procedures will be deleted. One code changed July 1, 2017 will be changed again January 1. Update CDM and paper charge order encounters. Blood Bank services require orders, so care must be taken to update all orders and order entry process accordingly. Educate providers, coders and billers.

HCPCS	CMS Short Description	Suggested Replacement	Suggested Description	Comment
P9072	Plate path red/ rapid bac tes	P9073	PLATELETS, PHERESIS, PATHOGEN-REDUCED, EACH UNIT	Deleted July 1 and replaced with Q9988, which will be deleted effective 1/1/18
Q9987	Pathogen test for platelets	P9100	PATHOGEN(S) TEST FOR PLATELETS	
Q9988	Platelets, pathogen reduced	P9073	PLATELETS, PHERESIS, PATHOGEN-REDUCED, EACH UNIT	

SURGERY PROCEDURE DELETIONS

Twenty surgical procedure codes will be deleted. In many cases, changes include combining radiological services. CDM pricing should take radiology services into consideration. Finance should be updated for the decrease in radiology utilization. Providers, coders and billers should be educated.

Surgery Procedure Deletions

HCPCS	CMS Short Description	Suggested Replacement	Replacement Long Description	Action
G0364	Bone marrow aspirate &biopsy	38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)	New code includes multiple Biopsies and aspirations as necessary. Educate providers, coders and billers. Update CMD and Order Entry
15732	Muscle-skin graft head/neck	15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)	New Code includes named vascular pedicle. Update CDM and encounter charge sheets. Educate providers and coders.
29582	Apply multlay comprs upr leg	29581		Deleted code specifies Thigh leg, ankle and foot when performed. See 29581, Specifies leg below knee, ankle and foot. Update CDM and encounter charge sheets. Educate providers and coders.
29583	Apply multlay comprs upr arm	29584		29584 includes upper arm, fore arm hand and fingers. Update CDM and encounter charge sheets. Educate providers and coders.
31320	Diagnostic incision larynx			
34800	Endovas aaa repr w/sm tube	34701-34708		Removed from IP only list. Notify coding, providers and case management. Review Order sets to ensure procedure is not automatically ordered as IP if not necessary.

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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Surgery Procedure Deletions

HCPCS	CMS Short Description	Suggested Replacement	Replacement Long Description	Action
34802	Endovas aaa repr w/2-p part	34701-34708		Removed from IP only list. Notify coding, providers and case management. Review Order sets to ensure procedure is not automatically ordered as IP if not necessary.
34803	Endovas aaa repr w/3-p part	34701-34708		Removed from IP only list. Notify coding, providers and case management. Review Order sets to ensure procedure is not automatically ordered as IP if not necessary.
34804	Endovas aaa repr w/1-p part	34701-34708		Removed from IP only list. Notify coding, providers and case management. Review Order sets to ensure procedure is not automatically ordered as IP if not necessary.
34805	Endovas aaa repr w/long tube	34701-34708		Removed from IP only list. Notify coding, providers and case management. Review Order sets to ensure procedure is not automatically ordered as IP if not necessary.
34806	Aneurysm press sensor add-on	34701-34708		Removed from IP only list. Notify coding, providers and case management. Review Order sets to ensure procedure is not automatically ordered as IP if not necessary.
34825	Endovasc extend prosth init	34709-34711		Removed from IP only list. Notify coding, providers and case management. Review Order sets to ensure procedure is not automatically ordered as IP if not necessary.
34826	Endovasc exten prosth addl	34709-34711		Removed from IP only list. Notify coding, providers and case management. Review Order sets to ensure procedure is not automatically ordered as IP if not necessary.
34900	Endovasc iliac repr w/graft	34707-34708		Removed from IP only list. Notify coding, providers and case management. Review Order sets to ensure procedure is not automatically ordered as IP if not necessary.
36120	Establish access to artery			
36515	Apheresis adsorp/reinfuse	36516		Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion
55450	Ligation of sperm duct	55250		Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
64565	Implant neuroelectrodes			
69820	Establish inner ear window			
69840	Revise inner ear window			

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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PROFESSIONAL CODE DELETIONS

PQR DELETIONS

Physician Quality Reporting codes are not reportable by facilities. Review professional CDM components for possible updates. Deleted PQR measures should be reviewed if deleted, and consider replacement measures where appropriate. Nine PQR measures will be deleted effective January 1.

HCPCS	CMS Short Description
G8696	Antithromb thx presc
G8697	Antithromb no presc doc reas
G8698	Antithromb no presc no reas
G8879	Node neg inv brst cncr
G8947	1 or more neuropsych
G8971	Warfrn or othr antcog no rx
G8972	1>=risk or>= mod risk for te
G9381	Doc med reas no offer eol
G9496	Doc rsn no adeno/neopl detec

ANESTHESIA DELETIONS

Five anesthesia codes will be deleted effective January 1. Replacement options are noted where available. The anesthesia code for the primary procedure should be reported. Update CDM, and educate providers, coders and billers.

HCPCS	CMS Short Description	Suggested Replacement	Comment
00740	Anesth upper gi visualize	00731-00732	New codes specify ERCP or NOS.
00810	Anesth low intestine scope	00811-00813	New codes specify NOS, screening colonoscopy, or upper and lower combined.
01180	Anesth pelvis nerve removal		
01190	Anesth pelvis nerve removal		
01682	Anesth airplane cast		See code for NOS, 01680.

REDUCTION IN REIMBURSEMENT FOR COMPUTED RADIOLOGY IMAGES

CMS continues to incentivize implementation of digital radiography, and to reduce payment for other x-ray methods of imaging. In 2017, CMS implemented modifier FX to identify x-rays taken using film, and applied a 20% reduction to OPPS payment. For 2018, CMS added a payment reduction of 7% for all images taken using computed radiography technology. Modifier FY must be reported to identify those HCPCS codes that describe x-rays taken using computed radiography technology. The payment reduction will increase to 10% in 2023. Reductions apply to payments that would otherwise be made under the OPPS. No reduction will be taken for packaged payments when the packaged payment includes radiology services, regardless of the technology used.

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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INPATIENT ONLY PROCEDURES

The 2018 Inpatient Only list contains 86 anesthesia codes and 1661 surgical codes. One procedure was added to the Inpatient Only List:

- 92941 - (percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, single vessel)

CMS has also removed Total Knee Arthroplasty, 27447 - (arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing [total knee arthroplasty]), from the Inpatient Only procedure list. Surgical advances, as well as advances in pain control, have contributed to short stays for knee replacements in many cases. Although this change is effective 1/1/2018, CMS has instructed Recovery Audit Contractors that total knee arthroplasty should not be audited for dates of service in 2018 or 2019. CMS believes this should allow all facilities and providers to adjust practices. CMS will also monitor Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) program practices to determine how they may be impacted by this change, and acknowledges that initially, they expect very few changes in the inpatient status. Although these cases will not be audited by RAC in the next few years, procedures should be carefully monitored by PPS hospitals to evaluate impact to bundling models.

In addition, several laparoscopic procedures have been removed from the Inpatient Only list. All codes removed from the Inpatient Only list will migrate to J1 status indicator, and J1 bundling rules will apply to the entire encounter for facilities paid via HOPPS.

The entire list can be found in Addendum E, at:

https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1678-FC-2018-OPPS-FR-Addenda.zip

DESCRIPTION CHANGES

Each year, the AMA changes CPT descriptions for many CPT codes. Description changes can be made for many reasons, such as the following:

- For grammatical clarification – not commented in this review
- To offer clarity. Reviews are suggested to improve the Description name in the CDM and to educate users regarding the intent of the code.
- To change the intent or use of CPT to accommodate new codes, or to combine services previously reported separately. Significant changes require education of providers, coders and departments. CDM descriptions should be updated. Order sets should be reviewed and corrected where services are either combined or subdivided.

Ninety-one CDM codes should be reviewed for clarification or changes in the intended service reported. CPT revision should be included in quarterly and annual review practices. The revised codes are included as an attachment to this document.

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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APC ADJUSTMENT

Each year, CMS evaluates the cost-to-charge ratio of each service and revalues CPTs and HCPCS by assigning services to more appropriate APCs. APCs may also be adjusted if a description change results in the inclusion of services that were previously separately reported, or the exclusion of services previously bundled. Assigned fees should be reassessed each time APC assignment is changed to determine if the fee is still appropriate for the service represented by a CPT. For example, if a procedure description changes to include radiological guidance or pathology services that were previously reimbursed separately, the fee should be evaluated relative to the cost of the two combined services. APC changes should be reviewed by Finance to mitigate revenue leakage and ensure realistic, competitive pricing.

ADDITIONAL COMMENTS

Chargemaster review should be performed quarterly, with a comprehensive review annually. All CDM reviews should include a sweep of all previously deleted codes. CPTs and HCPCS are recycled to represent entirely new services, so care should be taken to compare current CDM descriptions to current CPT descriptions. Corrections should be made where identified. Finance, billing compliance, coding and departments should be notified for possible correction projects.

Quarterly reviews should include:

- A comparison of new CDM code descriptions to CPT description, in order to identify transposed numbers typed in the CPT field. All discrepancies should be reviewed.
- Review of all injectable drugs reported with no HCPCS. New HCPCS may have been created, and should be reported. Revenue codes should be updated when detail HCPCS codes are added. Incorrectly representing detail-required drugs without HCPCS is problematic for several reasons:
    - Reimbursement may be appropriate for many injectable medications, and lack of HCPCS assignment may result in missed revenue opportunities
    - Units cannot be properly assessed without HCPCS and appropriate HCPCS level multipliers
    - Inability to track HCPCS for narcotic medication does not allow for effective control
    - Missing HCPCS may unintentionally circumvent pre-authorization or medical necessity limitations
- Procedures lacking CPT or HCPCS should be reviewed to ensure that chargeable services are represented by the most appropriate CPT or HCPCS

ATTACHMENTS

Codes Deleted January 2018

New 2018 CPTs with Long Description

2018 Significantly Revised CPTs

New 2018 HCPCS

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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Codes Deleted January 2018

HCPCS	CMS Short Description	Deleted Date	Suggested Replacement	Replacement Long Description	Action	2017 Payment	2018 Payment	Payment Change	APC 2017	APC 2018	APC Change
G0502	Init psych care manag, 70min	1/1/18	See: 99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	HCPCS replaced by new CPT. Update CDM and charge encounter forms. Educate coders, providers and billers.	70.23	71.94	-1.71	5822	5822	No Change

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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Codes Deleted January 2018

HCPCS	CMS Short Description	Deleted Date	Suggested Replacement	Replacement Long Description	Action	2017 Payment	2018 Payment	Payment Change	APC 2017	APC 2018	APC Change
G0503	Subseq psych care man,60mi	1/1/18	See: 99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.	HCPCS replaced by new CPT. Update CDM and charge encounter forms. Educate coders, providers and billers.	70.23	71.94	-1.71	5822	5822	No Change
G0504	Init/sub psych care add 30 m	1/1/18	See: 99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)	HCPCS replaced by new CPT. Update CDM and charge encounter forms. Educate coders, providers and billers.	0	0.00	0.00		0	Review APC Change

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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Codes Deleted January 2018

HCPCS	CMS Short Description	Deleted Date	Suggested Replacement	Replacement Long Description	Action	2017 Payment	2018 Payment	Payment Change	APC 2017	APC 2018	APC Change
G0505	Cog/func assessment outpt	1/1/18	See: 99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.	HCPCS replaced by new CPT. Update CDM and charge encounter forms. Educate coders, providers and billers.	70.23	71.94	-1.71	5822	5822	No Change

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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Codes Deleted January 2018

HCPCS	CMS Short Description	Deleted Date	Suggested Replacement	Replacement Long Description	Action	2017 Payment	2018 Payment	Payment Change	APC 2017	APC 2018	APC Change
G0507	Care manage serv minimum 20	1/1/18	See: 99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.	HCPCS replaced by new CPT. Update CDM and charge encounter forms. Educate coders, providers and billers.		30.41	-30.41	5821	5821	No Change
93982	Aneurysm pressure sens study	1/1/18					#N/A	#N/A	5721	#N/A	#N/A
94620	Pulmonary stress test/simple	1/1/18	See: 94618	Pulmonary stress testing (e.g., 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed	420	275	105.03	169.97	5734	5734	No Change
97532	Cognitive skills development	1/1/18	See: 97127	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact			0.00	0.00		0	Review APC Change
97762	C/o for orthotic/prosth use	1/1/18	See: 97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes			0.00	0.00		0	Review APC Change

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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99363	Anticoagulant mgmt initial	1/1/18	See: 93792-93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed	Re-ordered code. New code focus is on patient training, not management. Update OE, CDM and charge sheet encounter forms. Educate departments, providers, coders and billers.		0.00	0.00		0	Review APC Change
99364	Anticoagulant mgmt subseq	1/1/18	See: 93792-93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed	Re-ordered code. Update OE, CDM and charge sheet encounter forms. Educate departments, providers, coders and billers.		0.00	0.00		0	Review APC Change

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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New 2018 CPTs with Long Description

Code	Long Description	Actions
0500T	Infectious agent detection by nucleic acid (DNA or RNA), human papillomavirus (HPV) for five or more separately reported high-risk HPV types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) (i.e., genotyping)	Update Pro/Tech CDM. Educate Billers, Coders, and Providers
87634	Infectious agent detection by nucleic acid (DNA or RNA); respiratory syncytial virus, amplified probe technique	Update Pro/Tech CDM. Educate Billers, Coders, and Providers
87662	Infectious agent detection by nucleic acid (DNA or RNA); Zika virus, amplified probe technique	Update Pro/Tech CDM. Educate Billers, Coders, and Providers

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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2018 Significantly Revised CPTs

CPT	Description		Change	Action
17250	Chemical cauterization of granulation tissue (i.e., proud flesh)	1/1/2018	Add i.e. ***sinus or fistul***	Educate providers and coders
31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)	1/1/2018	change semicolon to comma	No Action
31255	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)	1/1/2018	change semicolon to comma	No Action
31276	Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed	1/1/2018	add ***including removal of tissue from frontal sinus, when performed***	Educate providers and coders
31645	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial	1/1/2018	remove ***(e.g., drainage of lung abscess)***	Educate providers and coders
31646	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay	1/1/2018	add ***same hospital stay***	Educate providers and coders
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	1/1/2018	add: ***including imaging guidance when performed***	Update CDM, inform Finance of change to reimbursement structure, educate providers and coders
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	1/1/2018	add: ***(List separately in addition to code for primary procedure)***	Educate providers and coders
34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	1/1/2018	add: ***(List separately in addition to code for primary procedure)***	Educate providers and coders
34833	Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	1/1/2018	add: ***or for establishment of cardiopulmonary bypass, Add: (List separately in addition to code for primary procedure)***	Educate providers and coders
34834	Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)	1/1/2018	Change to ***Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral***	Educate providers and coders

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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2018 Significantly Revised CPTs

CPT	Description		Change	Action
36140	Introduction of needle or intracatheter, upper or lower extremity artery	1/1/2018	Add ***or lowerextremity***	Change CDM, educate providers and coders
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	1/1/2018	Remove: ***Single or multiple***	No Action
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	1/1/2018	Add: ***single incompetent vein (other than telangiectasia)***	Educate providers and coders
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	1/1/2018	Add: ***incompetent vein (other than telangiectasia)***	Educate providers and coders
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion	1/1/2018	Add: ***immunoadsorption,***	Educate providers and coders
36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	1/1/2018	Added: ***And***	No Action
38220	Diagnostic bone marrow; aspiration(s)	1/1/2018	Added: ***Diagnostic,*** Removed: ***Only***	Educate providers and coders
38221	Diagnostic bone marrow; biopsy(ies)	1/1/2018	Added: ***Diagnostic,*** **and pluralized,** Added ***Needle or Trocar,***	Educate providers and coders
43112	Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (i.e., McKeown esophagectomy or tri-incisional esophagectomy)	1/1/2018	Added: ***(i.e., McKeown esophagectomy or tri-incisional esophagectomy)***	Educate providers and coders
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed	1/1/2018	Added: ***including cystourethroscopy, when performed***	Update CDM, inform Finance of change to reimbursement structure, educate providers and coders

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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2018 Significantly Revised CPTs

CPT	Description		Change	Action
57260	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed	1/1/2018	Added: ***including cystourethroscopy, when performed***	Update CDM, inform Finance of change to reimbursement structure, educate providers and coders
57265	Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair	1/1/2018	Added: ***including cystourethroscopy, when performed***	Update CDM, inform Finance of change to reimbursement structure, educate providers and coders
64550	Application of surface (transcutaneous) neurostimulator (e.g., TENS unit)	1/1/2018	Added: ***(e.g., TENS unit)***	No Action
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	1/1/2018	Removed: ***other than 71023 or 71034 (e.g., cardiac fluoroscopy)***	Educate providers and coders
76881	Ultrasound, complete joint (i.e., joint space and peri-articular soft tissue structures) real-time with image documentation	1/1/2018	Change from: ***Ultrasound, extremity, nonvascular, real-time with image documentation; complete***	Change CDM, educate providers and coders
76882	Ultrasound, limited, joint or other nonvascular extremity structure(s) (e.g., joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft tissue structure[s], or soft tissue mass[es]), real-time with image documentation	1/1/2018	Change from: ***Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific***	Change CDM, educate providers and coders
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service	1/1/2018	Changed to cups, cards, ***or*** cartridges	No Action
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service	1/1/2018	Changed to cups, cards, ***or*** cartridges	No Action

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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CPT	Description		Change	Action
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service	1/1/2018	Changed to cups, cards, ***or*** cartridges	No Action
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (e.g., Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)	1/1/2018	Removed and from: Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, ***and*** Constant Spring)	No Action
81400	MOLECULAR PATHOLOGY PROCEDURE LEVEL 1	1/1/2018	Included in primary procedure reimbursement when performed with FB/FC procedures	Notify Finance of change in reimbursement
81401	MOLECULAR PATHOLOGY PROCEDURE LEVEL 2	1/1/2018	Included in primary procedure reimbursement when performed with FB/FC procedures	Notify Finance of change in reimbursement
81403	MOLECULAR PATHOLOGY PROCEDURE LEVEL 4	1/1/2018	Included in primary procedure reimbursement when performed with FB/FC procedures	Notify Finance of change in reimbursement
81404	MOLECULAR PATHOLOGY PROCEDURE LEVEL 5	1/1/2018	Included in primary procedure reimbursement when performed with FB/FC procedures	Notify Finance of change in reimbursement
81405	MOLECULAR PATHOLOGY PROCEDURE LEVEL 6	1/1/2018	Included in primary procedure reimbursement when performed with FB/FC procedures	Notify Finance of change in reimbursement
81406	MOLECULAR PATHOLOGY PROCEDURE LEVEL 7	1/1/2018	Included in primary procedure reimbursement when performed with FB/FC procedures	Notify Finance of change in reimbursement

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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CPT	Description		Change	Action
81432	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, and TP53	1/1/2018	Requirement changed from 14 to 10 genes. Removed BRIP1 and RAD51C	Educate providers and coders
81439	Hereditary cardiomyopathy (e.g., hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy), genomic sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-related genes (e.g., DSG2, MYBPC3, MYH7, PKP2, TTN)	1/1/2018	Changed Inherited to Hereditary	No Action
82042	Albumin; other source, quantitative, each specimen	1/1/2018	Removed ***Urine***	Educate providers and coders
82043	Albumin; urine (e.g., microalbumin), quantitative	1/1/2018	added: (e.g.,) to microalbumin	No Action
82044	Albumin; urine (e.g., microalbumin), semiquantitative (e.g., reagent strip assay)	1/1/2018	added: (e.g.,) to microalbumin	No Action
86003	Allergen specific IgE; quantitative or semiquantitative, crude allergen extract, each	1/1/2018	Added: ***crude allergen extract,***	Educate providers and coders
86005	Allergen specific IgE; qualitative, multiallergen screen (e.g., disk, sponge, card)	1/1/2018	changed to: (***e.g., disk, sponge, card)***	No Action
94621	Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings	1/1/2018	~~Pulmonary stress~~ Cardiopulmonary exercise testing; ~~complex~~ including measurements of CO2 production, O2 uptake, and electrocardiographic recordings	Change CDM, Educate providers and coders
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording	1/1/2018	Added: ***physician or other qualified health care professional (office) provided equipment,***	Change CDM, Educate providers and coders
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report	1/1/2018	Change to: ***analysis***, interpretation and report	Change CDM, Educate providers and coders

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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CPT	Description		Change	Action
95930	Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report	1/1/2018	Add: ***except glaucoma, with interpretation and report***	Change CDM, Educate providers and coders
96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day	1/1/2018	Change to: Photodynamic therapy by external application of light to destroy premalignant ~~and/or malignant~~ lesions of the skin and adjacent mucosa ~~(e.g., lip)~~ by activation of photosensitive drug(s), ***each phototherapy exposure session***	Change CDM, Educate providers and coders
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	1/1/2018	Add: ***initial orthotic(s) encounter,***	Change CDM, Educate providers and coders
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	1/1/2018	Add: ***initial orthotic(s) encounter,***	Change CDM, Educate providers and coders
99217	Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])	1/1/2018	Included in Community Health Accountable Care (C-HAC)	ACO requires reimbursement model

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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2018 Significantly Revised CPTs

CPT	Description		Change	Action
99218	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.	1/1/2018	Included in Community Health Accountable Care (C-HAC)	ACO requires reimbursement model
99219	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	1/1/2018	Included in Community Health Accountable Care (C-HAC)	ACO requires reimbursement model
99220	Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.		Included in Community Health Accountable Care (C-HAC)	ACO requires reimbursement model
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed		This code was not recognized by Medicare in 2017, and was reported with HCPCS. HCPCS has been deleted, and CPT is now accepted by Medicare	

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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2018 Significantly Revised CPTs

CPT	Description	Change	Action
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	This code was not recognized by Medicare in 2017, and was reported with HCPCS. HCPCS has been deleted, and CPT is now accepted by Medicare	
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	This code was not recognized by Medicare in 2017, and was reported with HCPCS. HCPCS has been deleted, and CPT is now accepted by Medicare	

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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New 2018 HCPCS

HCPC	LONG DESCRIPTION	SHORT DESCRIPTION
G9894	Androgen deprivation therapy prescribed/administered in combination with external beam radiotherapy to the prostate	Adr dep thrpy prescribed
G9942	Patient had any additional spine procedures performed on the same date as the lumbar discectomy/laminotomy	Adtl spine proc on same date
G9948	Patient had any additional spine procedures performed on the same date as the lumbar discectomy/laminotomy	Adtl spine proc on same date
J7345	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg	Aminolevulinic acid, 10% gel
Q4181	Amnio wound, per square centimeter	Amnio wound, per square cm
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each	Aoi transducer/actuator repl
G9946	Back pain was not measured by the visual analog scale (vas) within three months preoperatively and at one year (9 to 15 months) postoperatively	Bk pn nt msr vas pre-pst 1y
G9943	Back pain was not measured by the visual analog scale (vas) within three months preoperatively and at three months (6 - 20 weeks) postoperatively	Bk pn nt msr vas scl pre/pst
C9738	Adjunctive blue light cystoscopy with fluorescent imaging agent (list separately in addition to code for primary procedure)	Blue light cysto imag agent
C9015	Injection, c-1 esterase inhibitor (human), haegarda, 10 units	C-1 esterase, haegarda
G9933	Adenoma(s) or colorectal cancer detected during screening colonoscopy	Canc detectd during col scrn
G9935	Adenoma(s) or colorectal cancer not detected during screening colonoscopy	Canc not detectd during srcn
G0511	Rural health clinic or federally qualified health center (rhc or fqhc) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an rhc or fqhc practitioner (physician, np, pa, or cnm), per calendar month	Ccm/bhi by rhc/fqhc 20min mo
L8625	External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each	Charger coch impl/aoi battry
J0604	Cinacalcet, oral, 1 mg, (for esrd on dialysis)	Cinacalcet, esrd on dialysis

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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New 2018 HCPCS

HCPC	LONG DESCRIPTION	SHORT DESCRIPTION
G0512	Rural health clinic or federally qualified health center (rhc/fqhc) only, psychiatric collaborative care model (psychiatric cocm), 60 minutes or more of clinical staff time for psychiatric cocm services directed by an rhc or fqhc practitioner (physician, np, pa, or cnm) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month	Cocm by rhc/fqhc 60 min mo
G0515	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes	Cognitive skills development
G9930	Patients who are receiving comfort care only	Com care
G9956	Patient received combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	Combo thrpy of >= 2 prophly
G9937	Diagnostic colonoscopy	Dig or surv colsco
G9977	Dilated macular exam was not performed, reason not otherwise specified	Dil mac exam no perf rsn nos
G9974	Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage and the level of macular degeneration severity	Dil mac exam performed
G9895	Documentation of medical reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate (e.g., salvage therapy)	Doc med rsn no adr dep thrpy
G9957	Documentation of medical reason for not receiving combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively (e.g., intolerance or other medical reason)	Doc med rsn no combo thrpy
G9891	Documentation of medical reason(s) for not performing a dilated macular examination	Doc med rsn no dil mac exam
G9917	Documentation of medical reason(s) for not performing functional status (e.g., patient is severely impaired and caregiver knowledge is limited, other medical reason)	Doc med rsn no funct status
G9975	Documentation of medical reason(s) for not performing a dilated macular examination	Doc med rsn no mac exm perf
G9924	Documentation of medical reason(s) for not providing safety concerns screen or for not providing recommendations, orders or referrals for positive screen (e.g., patient in palliative care, other medical reason)	Doc med rsn no scrn or recs
G9907	Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)	Doc med rsn no tbco interv

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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New 2018 HCPCS

HCPC	LONG DESCRIPTION	SHORT DESCRIPTION
G9909	Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user (e.g., limited life expectancy, other medical reason)	Doc med rsn no tbco interv
G9904	Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)	Doc med rsn no tbco scrn
G9927	Documentation of system reason(s) for not prescribing warfarin or another fda-approved anticoagulation due to patient being currently enrolled in a clinical trial related to af/atrial flutter treatment	Doc no warf /fda pt trial
G9976	Documentation of patient reason(s) for not performing a dilated macular examination	Doc pat rsn no mac exm perf
G9896	Documentation of patient reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate	Doc pt rsn no adr dep thrpy
G9892	Documentation of patient reason(s) for not performing a dilated macular examination	Doc pt rsn no dil mac exam
G9932	Documentation of patient reason(s) for not having records of negative or managed positive tb screen (e.g., patient does not return for mantoux (ppd) skin test evaluation)	Doc pt rsn no tb scrn recrds
G9940	Documentation of medical reason(s) for not on a statin (e.g., pregnancy, in vitro fertilization, clomiphene rx, esrd, cirrhosis, muscular pain and disease during the measurement period or prior year)	Doc reas no statin therapy
G9934	Documentation that neoplasm detected is only diagnosed as traditional serrated adenoma, sessile serrated polyp, or sessile serrated adenoma	Doc rsn not detecting cancer
G9962	Embolization endpoints are documented separately for each embolized vessel and ovarian artery angiography or embolization performed in the presence of variant uterine artery anatomy	Embolization doc separatly
G9963	Embolization endpoints are not documented separately for each embolized vessel or ovarian artery angiography or embolization not performed in the presence of variant uterine artery anatomy	Embolization not doc separat
L3761	Elbow orthosis (eo), with adjustable position locking joint(s), prefabricated, off-the-shelf	Eo, adj lock joint prefab ot
Q4177	Floweramnioflo, 0.1 cc	Floweramnioflo, 0.1 cc
Q4178	Floweramniopatch, per square centimeter	Floweramniopatch, per sq cm
Q4179	Flowerderm, per square centimeter	Flowerderm, per sq cm
E0954	Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot	Foot box, any type each foot

Laurie Daigle, CPC
Informatics Specialist
ldaigle@stroudwater.com
207-221-8274

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HCPC	LONG DESCRIPTION	SHORT DESCRIPTION
G9916	Functional status performed once in the last 12 months	Funct status past 12 months
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	Gemtuzumab ozogamicin 0.1 mg
G9912	Hepatitis b virus (hbv) status assessed and results interpreted prior to initiating anti-tnf (tumor necrosis factor) therapy	Hbv status assesed and int
G9955	Cases in which an inhalational anesthetic is used only for induction	Inhlnt anesth only for induc
J1555	Injection, immune globulin (cuvitru), 100 mg	Inj cuvitru, 100 mg
J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	Inj hydroxyprogst capoat nos
J7210	Injection, factor viii, (antihemophilic factor, recombinant), (afstyla), 1 i.u.	Inj, afstyla, 1 i.u.
J9022	Injection, atezolizumab, 10 mg	Inj, atezolizumab,10 mg
J0565	Injection, bezlotoxumab, 10 mg	Inj, bezlotoxumab, 10 mg
C9024	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	Inj, daunorubicin-cytarabine
J0606	Injection, etelcalcetide, 0.1 mg	Inj, etelcalcetide, 0.1 mg
J1428	Injection, eteplirsen, 10 mg	Inj, eteplirsen, 10 mg
J1627	Injection, granisetron, extended-release, 0.1 mg	Inj, granisetron, xr, 0.1 mg
J7211	Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.	Inj, kovaltry, 1 i.u.
J2326	Injection, nusinersen, 0.1 mg	Inj, nusinersen, 0.1mg
J9285	Injection, olaratumab, 10 mg	Inj, olaratumab, 10 mg
C9016	Injection, triptorelin extended release, 3.75 mg	Inj, triptorelin ext rel
C9028	Injection, inotuzumab ozogamicin, 0.1 mg	Inj. inotuzumab ozogamicin
J9023	Injection, avelumab, 10 mg	Injection, avelumab, 10 mg
C9014	Injection, cerliponase alfa, 1 mg	Injection, cerliponase alfa
C9029	Injection, guselkumab, 1 mg	Injection, guselkumab
J2350	Injection, ocrelizumab, 1 mg	Injection, ocrelizumab, 1 mg
G0516	Insertion of non-biodegradable drug delivery implants, 4 or more (services for subdermal rod implant)	Insert drug del implant, >4
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (kyleena), 19.5 mg	Kyleena, 19.5 mg

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HCPC	LONG DESCRIPTION	SHORT DESCRIPTION
G9949	Leg pain was not measured by the visual analog scale (vas) within three months preoperatively and at three months (6 to 20 weeks) postoperatively	Lg pn nt msr vas scl pre/pst
G9890	Dilated macular exam performed, including documentation of the presence or absence of macular thickening or geographic atrophy or hemorrhage and the level of macular degeneration severity	Mac exam perf
J1726	Injection, hydroxyprogesterone caproate, (makena), 10 mg	Makena, 10 mg
G9960	Documentation of medical reason(s) for prescribing systemic antimicrobials	Med rsn sys antimi nt rx
Q4176	Neopatch, per square centimeter	Neopatch, per sq centimeter
G9931	Documentation of cha2ds2-vasc risk score of 0 or 1	No chad or chad scr 0 or 1
G9958	Patient did not receive combination therapy consisting of at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and/or intraoperatively	No combo prohpyl thrp for pt
G9915	No record of hbv results documented	No documntd hbv results rcd
G9918	Functional status not performed, reason not otherwise specified	No funct stat perf, rsn nos
G9913	Hepatitis b virus (hbv) status not assessed and results interpreted prior to initiating anti-tnf (tumor necrosis factor) therapy, reason not given	No hbv status assesd and int
G9893	Dilated macular exam was not performed, reason not otherwise specified	No mac exam
G9921	No screening performed, partial screening performed or positive screen without recommendations and reason is not given or otherwise specified	No or part scrn nd rng or os
G9908	Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given	No pt tbco cess interv rng
G9905	Patient not screened for tobacco use, reason not given	No pt tbco scrn rng
G9925	Safety concerns screening not provided, reason not otherwise specified	No scrn prov rsn nos
G9967	Children who were not screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report	No scrn, inter, reprt child
G9928	Warfarin or another fda-approved anticoagulant not prescribed, reason not given	No warf or fda drug presc
G9965	Patient did not receive at least one well-child visit with a pcp during the performance period	No well-chld vist recv by pt
G9911	Clinically node negative (t1n0m0 or t2n0m0) invasive breast cancer before or after neoadjuvant systemic therapy	Node neg pre/post syst ther

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HCPC	LONG DESCRIPTION	SHORT DESCRIPTION
P9100	Pathogen(s) test for platelets	Pathogen test for platelets
P9073	Platelets, pheresis, pathogen-reduced, each unit	Platelets, pathogen reduced
G9936	Surveillance colonoscopy - personal history of colonic polyps, colon cancer, or other malignant neoplasm of rectum, rectosigmoid junction, and anus	Pmh plyp/neo co/rect/jun/ans
G9941	Back pain was measured by the visual analog scale (vas) within three months preoperatively and at three months (6 - 20 weeks) postoperatively	Pre and post vas wthn 3 mos
G9947	Leg pain was measured by the visual analog scale (vas) within three months preoperatively and at three months (6 to 20 weeks) postoperatively	Pre and post vas wthn 3 mos
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code g0513 for additional 30 minutes of preventive service)	Prolong prev svcs, addl 30m
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)	Prolong prev svcs, first 30m
L7700	Gasket or seal, for use with prosthetic socket insert, any type, each	Pros soc insert gasket/seal
C9748	Transurethral destruction of prostate tissue; by radiofrequency water vapor (steam) thermal therapy	Prostatic rf water vapor tx
G9954	Patient exhibits 2 or more risk factors for post-operative vomiting	Pt >2 rsk fac post-op vomit
G9897	Patients who were not prescribed/administered androgen deprivation therapy in combination with external beam radiotherapy to the prostate, reason not given	Pt nt prsc adr dep thrpy rng
G9914	Patient receiving an anti-tnf agent	Pt receiving anti-tnf agent
G9964	Patient received at least one well-child visit with a pcp during the performance period	Pt recv >=1 well-chld visit
G9906	Patient identified as a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy)	Pt recv tbco cess interv
G9968	Patient was referred to another provider or specialist during the performance period	Pt refrd 2 pvdr/spclst in pp
G9902	Patient screened for tobacco use and identified as a tobacco user	Pt scrn tbco and id as user

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G9903	Patient screened for tobacco use and identified as a tobacco non-user	Pt scrn tbco id as non user
G9945	Patient had cancer, fracture or infection related to the lumbar spine or patient had idiopathic or congenital scoliosis	Pt w/cancer scoliosis
G9970	Provider who referred the patient to another provider did not receive a report from the provider to whom the patient was referred	Pvdr rfrd pt no rprt rcvd
G9969	Provider who referred the patient to another provider received a report from the provider to whom the patient was referred	Pvdr rfrd pt rprt rcvd
Q0477	Power module patient cable for use with electric or electric/pneumatic ventricular assist device, replacement only	Pwr module pt cable lvad rpl
G0517	Removal of non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)	Remove drug implant
G0518	Removal with reinsertion, non-biodegradable drug delivery implants, 4 or more (services for subdermal implants)	Remove w insert drug implant
Q4180	Revita, per square centimeter	Revita, per sq cm
G9923	Safety concerns screen provided and negative	Safty cncrns scrn and neg
G9939	Pathologists/dermatopathologists is the same clinician who performed the biopsy	Same path/derm perf biopsy
G9899	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results documented and reviewed	Scrn mam perf rslts doc
G9900	Screening, diagnostic, film, digital or digital breast tomosynthesis (3d) mammography results were not documented and reviewed, reason not otherwise specified	Scrn mam perf rslts not doc
G9919	Screening performed and positive and provision of recommendations	Scrn nd pos nd prov of rec
G9966	Children who were screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report	Scrn, inter, report child
G9920	Screening performed and negative	Scrning perf and negative
G9926	Safety concerns screening positive screen is without provision of mitigation recommendations, including but not limited to referral to other resources	Sfty cncrns scrn but no recs
G9922	Safety concerns screen provided and if positive then documented mitigation recommendations	Sfty cncrns scrn nd mit recs

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G9898	Patient age 65 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54, or 56 any time during the measurement period	Snp/lg trm cre pt w/pos cde
G9901	Patient age 65 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54, or 56 any time during the measurement period	Snp/lg trm cre pt w/pos cde
G9910	Patients age 65 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54 or 56 anytime during the measurement period	Snp/lg trm cre pt w/pos cde
G9938	Patients age 65 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54, or 56 any time during the measurement period	Snp/lg trm cre pt w/pos cde
G9959	Systemic antimicrobials not prescribed	Systemic antimicro not presc
G9961	Systemic antimicrobials prescribed	Systemic antimicro presc
Q2040	Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	Tisagenlecleucel car-pos t
Q4182	Transcyte, per square centimeter	Transcyte, per sq centimeter
G9929	Patient with transient or reversible cause of af (e.g., pneumonia, hyperthyroidism, pregnancy, cardiac surgery)	Trs/rev af
J3358	Ustekinumab, for intravenous injection, 1 mg	Ustekinumab, iv inject, 1 mg
G9944	Back pain was measured by the visual analog scale (vas) within three months preoperatively and at one year (9 to 15 months) postoperatively	Vas 3 mon pre and 1 yr post
E0953	Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each	W/c lateral thigh/knee sup

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