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2019 CPT and ICD-10 Update

Doing It Right the First Time

Topics

- QPP and MACRA Update
- EM Changes now and in the Future
- Surgery Section
- Radiology Changes
- Pathology Changes
- ICD-10 Updates

Some Miscellaneous Issues First

The 2019 MPFS conversion factor is increasing slightly from $35.9996 this year to $36.0391

CMS will not apply the multiple procedure payment reduction policy to office visits and other services done at the same encounter.

CMS is continuing to help small practices in Year 3 of Quality Payment Program (QPP) by increasing the small practice bonus to six points, but including it in the Quality performance category score of clinicians in small practices instead of as a standalone bonus

QPP and MIPS

CMS also added an additional low-volume threshold exemption to MIPS for next year. To be excluded, providers or groups need to meet at least one of the following conditions:

1. Have $90,000 or less in Medicare Part B allowed charges for covered professional services.
2. Provide care to 200 or fewer Part B-enrolled patients.
3. Provide 200 or fewer covered professional services under the PFS.

QPP and MIPS

The minimum period for each performance category remains unchanged, so quality and cost stay at 12 months while improvement activities and promoting interoperability remain at a continuous 90-day period.

However, the weighting to the final score of the cost and quality categories have both changed. Cost increases from 10 percent to 15 percent of the total score, and quality drops from 50 percent to 45 percent.

Currently eligible clinician types include physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and groups that include such professionals (required by statute). Consistent with the MACRA statute, CMS is expanding participation in MIPS to include: physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals. CMS estimates that this change will expand the pool of MIPS-eligible clinicians by 20,240.

Change in Performance Threshold from Performance Year 2017–2019

Performance Year	Performance Threshold	Exceptional Performance Threshold
2019	30	75
2018	15	70
2017	3	70

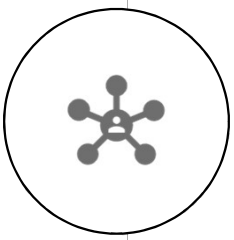
	Performance Score	Category Weith	Bonus Points	Earned Points
Promoting Interoperability	0	25%	0	0
Improvement Activities	40 out of 40	15%	0	15
Cost	0	15%	0	0
Quality	18 out of 60	45%	6	19.5
				34.5
Points earned / total possible points within the category x performance weight = score				

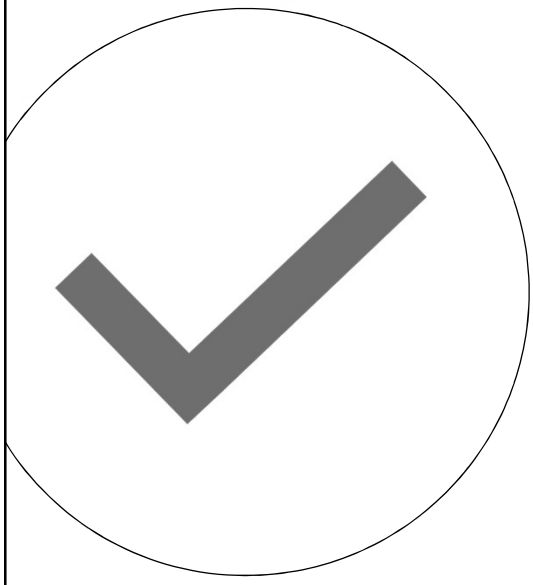
CPT/ HCPCS [1]	MOD	Short Descriptor	Facility			Non Facility		
			CY 2018 [2]	CY 2019 [3]	% Change	CY 2018 [2]	CY 2019 [3]	% Change
99203		Office/outpatient visit new	$78.12	$77.48	-1%	$109.80	$109.92	0%
99213		Office/outpatient visit est	$52.20	$51.90	-1%	$74.16	$75.32	2%
99214		Office/outpatient visit est	$79.92	$80.01	0%	$109.44	$110.28	1%
99222		Initial hospital care	$139.32	$139.11	0%	NA	NA	NA
99223		Initial hospital care	$206.64	$205.42	-1%	NA	NA	NA
99231		Subsequent hospital care	$39.96	$40.00	0%	NA	NA	NA
99232		Subsequent hospital care	$74.16	$73.88	0%	NA	NA	NA
99233		Subsequent hospital care	$106.20	$105.59	-1%	NA	NA	NA
99236		Observ/hosp same date	$222.48	$220.92	-1%	NA	NA	NA
99239		Hospital discharge day	$109.80	$108.84	-1%	NA	NA	NA
99283		Emergency dept visit	$63.00	$63.07	0%	NA	NA	NA
99284		Emergency dept visit	$119.52	$119.65	0%	NA	NA	NA
99291		Critical care first hour	$226.80	$226.33	0%	$279.36	$281.83	1%
99292		Critical care addl 30 min	$113.76	$113.52	0%	$124.92	$124.70	0%
99348		Home visit est patient	NA	NA	NA	$85.68	$85.41	0%
99350		Home visit est patient	NA	NA	NA	$182.16	$182.00	0%
G0008		Admin influenza virus vac	NA	NA	NA	NA	NA	NA

We proposed to expand this policy to further simplify the documentation of history and exam for established patients such that, for both of these key components, when relevant information is already contained in the medical record, practitioners would only be required to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting a defined list of required elements such as review of a specified number of systems and family/social history. Practitioners would still review prior data, update as necessary, and indicate in the medical record that they had done so. Practitioners would conduct clinically relevant and medically necessary elements of history and physical exam, and conform to the general principles of medical record documentation in the 1995 and 1997 guidelines. However, practitioners would not need to re-record these elements (or parts thereof) if there is evidence that the practitioner reviewed and updated the previous information.

Chief Complaint and HPI

Additionally, we are clarifying that for E/M office/outpatient visits, for new and established patients for visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information; and





Review and Validated

For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. *Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so.*

Teaching Physicians and Residents

Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.

New HCPCS Codes for 2019

Brief communication technology-based service, e.g. virtual check-in (HCPCS code G2012) and

Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010)

2019 Payments for Technology-Based Services			
Code	Descriptor	2019 Non-Facility Rate	2019 Facility Rate
G2010	Remot image submit by pt	$12.61	$9.37
G2012	Brief check in by md/qhp	$14.78	$13.33
99446	Ntrprof ph1/ntrnet/ehr 5-10	***	$18.38
99447	Ntrprof ph1/ntrnet/ehr 11-20	***	$36.40
99448	Ntrprof ph1/ntrnet/ehr 21-30	***	$54.78
99449	Ntrprof ph1/ntrnet/ehr 31/>	***	$72.80
99451	Ntrprof ph1/ntrnet/ehr 5/>	$37.48	$37.48
99452	Ntrprof ph1/ntrnet/ehr rfrl	$37.48	$37.48

G2012

(Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)

G2010

(Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment)

Definitions

Practitioners could be separately paid for the brief communication technology-based service when the patient checks in with the practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. This would increase efficiency for practitioners and convenience for beneficiaries.

Similarly, the service of remote evaluation of recorded video and/or images submitted by an established patient would allow practitioners to be separately paid for reviewing patient-transmitted photo or video information conducted via pre-recorded "store and forward" video or image technology to assess whether a visit is needed.

2021 Changes

Reduction in the payment variation for E/M office/outpatient visit levels by paying a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients while maintaining the payment rate for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients;

		Current (2018) Payment Amount	Revised Payment Amount***				
	Complexity Level under CPT	*Visit Code Alone**	*Visit Code Alone Payment*	*Visit Code With Either Primary or specialized care add-on code***	*Visit Code with New Extended Services Code (Minutes Required to Bill)*	*Visit with Both Add-on and Extended Services Code Added***	*Current Prolonged Code Added (Minutes Required to Bill)**
New Patient	Level 2	$76	$130	$143	$197 (at 38 minutes)	$210	
	Level 3	$110					
	Level 4	$167					
	Level 5	$211	$211				$344 (at 90 minutes)
Established Patient	Level 2	$45	$90	$103	$157 (at 34 minutes)	$170	
	Level 3	$74					
	Level 4	$109					
	Level 5	$148	$148				$281 (at 70 minutes)

	2018 Allowable	2018 Units	2021 Allowable	2018	2019
99212	$ 45.00	189	$ 103.00	$ 8,505.00	$ 19,467.00
99213	$ 74.00	1194	$ 103.00	$ 88,356.00	$ 122,982.00
99214	$ 109.00	1218	$ 103.00	$ 132,762.00	$ 125,454.00
99215	$ 148.00	1	$ 148.00	$ 148.00	$ 148.00
				$ 229,771.00	$ 268,051.00

	2018 Allowable	2018 Units	2021 Allowable	2018	2019
99202	$ 76.00	5	$ 143.00	$ 380.00	$ 715.00
99203	$ 110.00	50	$ 143.00	$ 5,500.00	$ 7,150.00
99204	$ 167.00	100	$ 143.00	$ 16,700.00	$ 14,300.00
99205	$ 211.00	15	$ 211.00	$ 3,165.00	$ 3,165.00
				$ 25,745.00	$ 25,330.00

Total 2018	Total 2019
$ 255,516.00	$ 293,381.00
Increase	$ 37,865.00

2021 Changes

Permitting practitioners to choose to document E/M office/outpatient level 2 through 5 visits using medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework;

2021 Changes

Beginning in CY 2021, for E/M office/outpatient levels 2 through 5 visits, we will allow for flexibility in how visit levels are documented - specifically, a choice to use the current framework, MDM, or time. For E/M office/outpatient level 2 through 4 visits, when using MDM or current framework to document the visit, we will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for history, exam and/or medical decision-making;

2021 Changes

When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary;

Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be restricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2 through 4 visits, and their use generally would not impose new per-visit documentation requirements.

2021 Changes

2021 Changes

Adoption of a new “extended visit” add-on code for use only with E/M office/outpatient services. To report extended time for E/M office and other outpatient E/M services when face-to-face time exceeds 34 minutes for an established patient or 38 minutes for a new patient whose E/M service is reported as level 2 through 4 and to report a level 5 code with prolonged service add-on code when face-to-face time exceeds 69 minutes for established patients or 89 minutes for new patients.

CPT Changes 2019

The new current procedural terminology (CPT®) codes have been released with **335** code changes in 2019. There were many code revisions with guideline, description and instructional note changes. Let’s look at the highlights of many new CPT codes for 2019.

Remote Monitoring

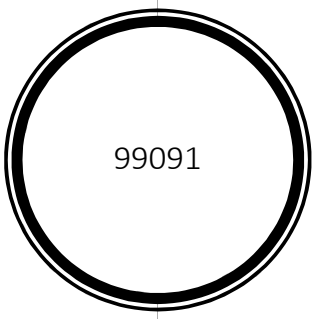
99453: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment

99454: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, **each** 30 days

Remote Monitoring

99457 (Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month **requiring interactive communication with the patient/caregiver during the month)**

Use 99457 for time spent managing care when patients or the practice do not meet the requirements to report more specific services - CPT explains.



#▲ **99091** Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days

CPT Changes: An Insider's View 2002, 2013, 2019

CPT Assistant May 02:19, Jun 03:10, Aug 06:6, Sep 06:15, Jan 07:30, Apr 09:7, Dec 09:6, Apr 13:3, Nov 13:3, Oct 14:3, Feb 18:7, Mar 18:5

►(Do not report 99091 in conjunction with 99457)◄

Differences

CPT Code 99457	CPT Code 99091
Requires 20 minutes of time spent	Requires 30 minutes
Based on a calendar month	Based on a 30-day period
Allows for time spent by clinical staff	Limited to Physicians and QHCPs

The Rule states that CPT Code 99457 describes only professional time and "therefore cannot be furnished by auxiliary personnel incident to a practitioner's professional services."

More to Come…

CMS stated in the Rule that it plans to issue further guidance to help practitioners and stakeholders determine the scope of service and better interpret the code descriptors listed above. Specifically, we can expect guidance on (i) the types of technology that can be used to provide these new RPM services, (ii) whether the descriptor for CPT Code 99454 includes transmissions that occur other than daily, and (iii) whether CPT Code 99453 can be furnished via telecommunication technology.

Proc. Code & Modifier	Par Fee	Non-Par Fee	Limiting Charge	Effective Date
99453	$17.56	$16.68	$19.18	01/01/2019
99454	$57.73	$54.84	$63.07	01/01/2019
99457	$48.80	$46.36	$53.31	01/01/2019

99091 $56.93

Fee Data

Interprofessional Consults

99446: Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review

99447: Same as 99446, but 11-20 minutes of medical consultative discussion and review

99448: Same as 99446, but 21-30 minutes of medical consultative discussion and review

99449: Same as 99446, but 31 minutes or more of medical consultative discussion and review

Interprofessional Consults

99451 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a **written report** to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time)

***99452** (Interprofessional telephone/Internet/electronic health record referral service[s] provided by a **treating/requesting physician** or other qualified health care professional, 30 minutes)

Interprofessional Consults

- 99446 $17.92
- 99447 $35.52
- 99448 $53.44
- 99449 $71.04
- 99451 $36.56
- 99452 $36.56

New for 2019

Imaging Guidance

►When imaging guidance or imaging supervision and interpretation is included in a surgical procedure, guidelines for image documentation and report, included in the guidelines for Radiology (Including Nuclear Medicine and Diagnostic Ultrasound), will apply. Imaging guidance should not be reported for use of a nonimaging-guided tracking or localizing system (eg, radar signals, electromagnetic signals). Imaging guidance should only be reported when an imaging modality (eg, radiography, fluoroscopy, ultrasonography, magnetic resonance imaging, computed tomography, or nuclear medicine) is used and is appropriately documented.◄

FNAB and a Core Needle Biopsy (CNB)

The FNAB involves aspiration of material with a fine needle and cytological examination of the cells.

A core needle biopsy involves obtaining a core sample with a larger bore needle and histopathologic examination of the tissue

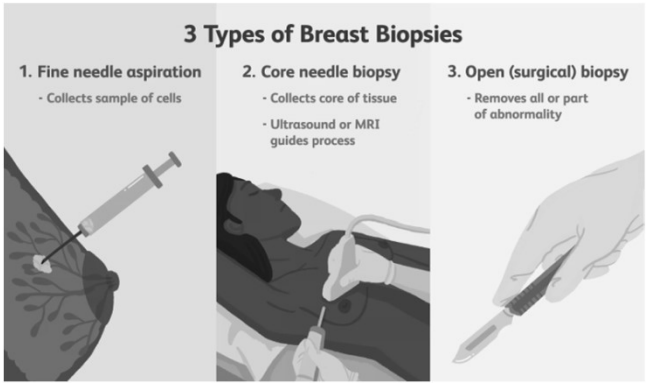
2019 FNAB Codes

10021 (Fine needle aspiration biopsy; without imaging guidance) will be revised to state "Fine needle aspiration biopsy; without imaging guidance; first lesion." When appropriate, a provider would report a new add-on code:

10004 (Each additional lesion [List separately in addition to code for primary procedure]).

Four more primary and add-on pairings will be available to report FNAB with

(**10005-10006**) – Ultrasound;
(**10007-10008**) – Fluoroscopy;
(**10009-10010**) – CT; or
(**10011-10012**) – MRI



(For percutaneous needle biopsy other than fine needle aspiration, see 19081-19086 for breast, 20206 for muscle, 32400 for pleura, 32405 for lung or mediastinum, 42400 for salivary gland, 47000 for liver, 48102 for pancreas, 49180 for abdominal or retroperitoneal mass, 50200 for kidney, 54500 for testis, 54800 for epididymis, 60100 for thyroid, 62267 for nucleus pulposus, intervertebral disc, or paravertebral tissue, 62269 for spinal cord)

Allowables

10004	$51.88
10005	$122.57
10006	$59.67
10007	$269.89
10008	$152.79
10009	$438.57
10010	$265.55
10021	$94.70

Biopsy Codes Deleted

11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion); and

+11101 (…; each separate/additional lesion [List separately in addition to code for primary procedure])

11102 (Tangential biopsy of skin [e.g., shave, scoop, saucerize, curette]; single lesion) and

+11103 (…, each separate/additional lesion [List separately in addition to code for primary procedure]

The definition states that the biopsy is performed - with a sharp blade, such as a flexible biopsy blade, obliquely oriented scalpel or curette to remove a sample of epidermal tissue with or without portions of the underlying dermis

11104 Punch biopsy of skin, single lesion

+11105 (…; each separate/additional lesion [List separately in addition to code for primary procedure]) also includes a simple closure

11106 Incisional biopsy of skin, single lesion

+11107 (…; each separate/additional lesion [List separately in addition to code for primary procedure]) also includes a simple closure

Allowables

11102	$93.68
11103	$50.62
11104	$117.76
11105	$58.06
11106	$142.57
11107	$68.50

Vulvectomy Notes

56630 Vulvectomy, radical, partial;

(For skin graft, if used, see 15004-15005, 15120, 15121, 15240, 15241)

56631 with unilateral inguinofemoral lymphadenectomy

56632 with bilateral inguinofemoral lymphadenectomy

►(For partial radical vulvectomy with inguinofemoral lymph node biopsy without complete inguinofemoral lymphadenectomy, use 56630 in conjunction with 38531)◄

56633 Vulvectomy, radical, complete;

56634 with unilateral inguinofemoral lymphadenectomy

56637 with bilateral inguinofemoral lymphadenectomy

►(For complete radical vulvectomy with inguinofemoral lymph node biopsy without complete inguinofemoral lymphadenectomy, use 56633 in conjunction with 38531)◄

Non-Image Guided Services

In addition, the new guidance warns practices that nonimage-guided tracking or localization – such as radar should not be reported with radiology codes.

According to CPT: - Imaging guidance should only be reported when an imaging modality (e.g., radiography, fluoroscopy, ultrasonography, magnetic resonance imaging, computed tomography, or nuclear medicine) is used and is appropriately documented the new guidance states.

Here It Is In Writing

According to the supervision and interpretation, imaging guidance section, all imaging guidance codes require image documentation in the patient chart and a description of the image guidance in the procedure note.

Radiological supervision and interpretation (S & I) documentation must include documentation in the patient's "permanent record" and a procedure or separate image report "that includes written documentation of interpretive findings of information contained in the images and radiologic supervision of the service."

In addition, new text in the written reports section states that for the purposes of descriptors for imaging services, the images "must contain anatomic information unique to the patient for which the imaging service is provided."

Breast MRI Procedures

CPT codes 77058 and 77059 were deleted.

Four new breast MRI procedures were added (77046-77049). Codes are selected based on laterality (unilateral vs. bilateral) and with or without contrast material.

Breast MRI Images

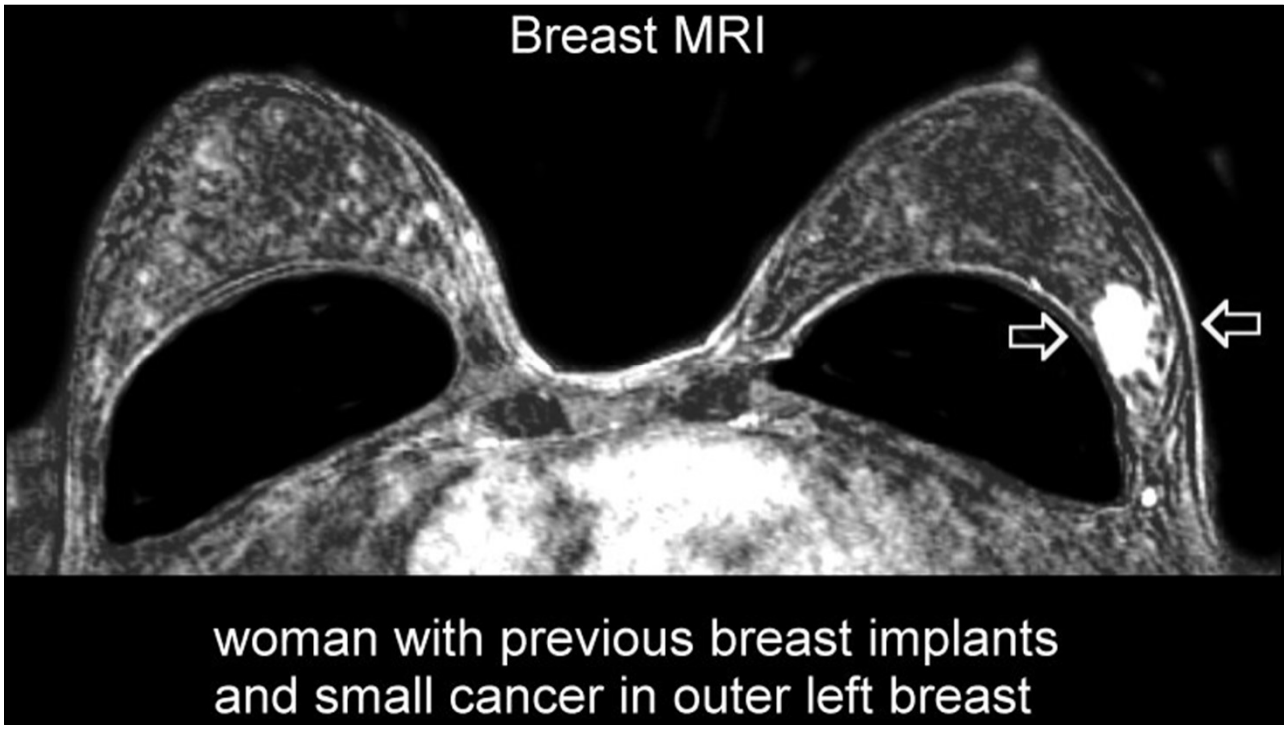
77046 Magnetic resonance imaging, breast, without contrast material unilateral

77047 bilateral

77048 Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed unilateral 3 CPT Changes:

77049 bilateral

(77051 has been deleted. To report, see 77065, 77066)
(77052 has been deleted. To report, use 77067



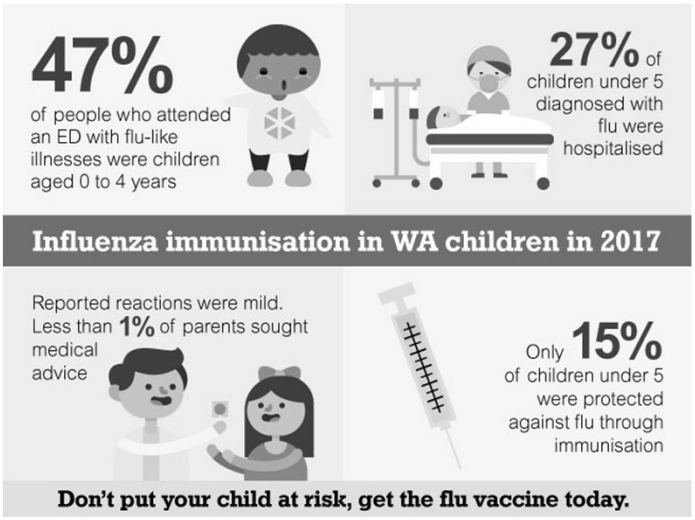
Pathology Changes

Due to frequent use, many services previously classified with the **Tier 2** molecular pathology codes are now described using standalone **Tier 1** codes like 81171-81183

The BRCA1 & BRCA2 codes have also been revised due to changes in clinical practice and are listed under **Tier 1 codes**

New Flu Vaccine

CPT code **90689** was added to report an inactivated adjuvanted preservative free flu vaccination.

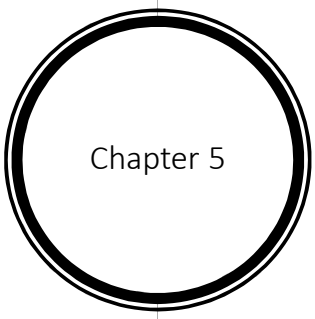


Chapter 4

E78.4 Other hyperlipidemia
Familial combined hyperlipidemia

E78.41 Elevated Lipoprotein(a)
Elevated Lp(a)

E78.49 Other hyperlipidemia
Familial combined hyperlipidemia



F12 Cannabis related disorders

F12.2 Cannabis dependence

F12.23 Cannabis dependence with withdrawal

F12.28 Cannabis dependence with other cannabis-induced disorder

F12.288 Cannabis dependence with other cannabis-induced disorder
Cannabis withdrawal

F12.9 Cannabis use, unspecified

F12.93 Cannabis use, unspecified with withdrawal

Chapter 11

K35.2 Acute appendicitis with generalized peritonitis
Perforated appendix NOS
Ruptured appendix NOS

K35.20 Acute appendicitis with generalized peritonitis, without abscess
(Acute) appendicitis with generalized peritonitis NOS

K35.21 Acute appendicitis with generalized peritonitis, with abscess

K35.3 Acute appendicitis with localized peritonitis
Acute appendicitis with or without perforation or rupture with peritonitis NOS
Acute appendicitis with or without perforation or rupture with localized peritonitis
Acute appendicitis with peritoneal abscess

K35.30 Acute appendicitis with localized peritonitis, without perforation or gangrene
Acute appendicitis with localized peritonitis NOS

K35.31 Acute appendicitis with localized peritonitis and gangrene, without perforation

K35.32 Acute appendicitis with perforation and localized peritonitis, without abscess
(Acute) appendicitis with perforation NOS
Perforated appendix NOS
Ruptured appendix (with localized peritonitis) NOS

K35.33 Acute appendicitis with perforation and localized peritonitis, with abscess
(Acute) appendicitis with (peritoneal) abscess NOS
Ruptured appendix with localized peritonitis and abscess

K35.8 Other and unspecified acute appendicitis

K35.89 Other acute appendicitis

K35.890 Other acute appendicitis without perforation or gangrene

K35.891 Other acute appendicitis without perforation, with gangrene
(Acute) appendicitis with gangrene NOS

Chapter 13

M79 Other and unspecified soft tissue disorders, not elsewhere classified

M79.1 Myalgia

M79.10 Myalgia, unspecified site

M79.11 Myalgia of mastication muscle

M79.12 Myalgia of auxiliary muscles, head and neck

M79.18 Myalgia, other site

Chapter 15

O86.0 Infection of obstetric surgical wound

Excludes1: complications of procedures, not elsewhere classified (T81.4-)
postprocedural fever NOS (R50.82)
postprocedural retroperitoneal abscess (K68.11)

O86.00 Infection of obstetric surgical wound, unspecified

O86.01 Infection of obstetric surgical wound, superficial incisional site
Subcutaneous abscess following an obstetrical procedure
Stitch abscess following an obstetrical procedure

O86.02 Infection of obstetric surgical wound, deep incisional site
Intramuscular abscess following an obstetrical procedure
Sub-fascial abscess following a procedure

O86.03 Infection of obstetric surgical wound, organ and space site
Intraabdominal abscess following an obstetrical procedure
Subphrenic abscess following an obstetrical procedure

O86.04 Sepsis following an obstetrical procedure

Use Additional code to identify the sepsis

O86.09 Infection of obstetric surgical wound, other surgical site

Chapter 21

Z13 Encounter for screening for other diseases and disorders

Z13.3 Encounter for screening examination for mental health and behavioral disorders

Z13.30 Encounter for screening examination for mental health and behavioral disorders, unspecified

Z13.31 Encounter for screening for depression
Encounter for screening for depression, adult
Encounter for screening for depression for child or adolescent

Z13.32 Encounter for screening for maternal depression
Encounter for screening for perinatal depression

Z13.39 Encounter for screening examination for other mental health and behavioral disorders

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Encounter for screening for alcoholism
Encounter for screening for intellectual disabilities

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