Key 2020 CPT®, ICD-10-CM and HCPCS Code Updates

Transcript from Live Session

Wednesday, June 24, 2020

April Faulkner:

The Quality Insights QPP Support Center Team welcomes you to today's webinar, Key 2020 CPT®, ICD-10-CM and HCPCS Code Updates. We'll take just a moment to review a few items before we begin the presentation.

April Faulkner:

All participants entered today's webinar in a listen-only mode. Should you have a question during today's presentation, please type it in the chat or Q&A box at the bottom right of your screen. We will address questions at the end of the presentation, as time permits. Today's webinar is being recorded. The recording, along with the slide deck, and a transcript of the webinar will be posted on the Quality Insights QPP support center website within the next few days. These resources can be found on the Archived Events page. We have posted a link to that page in the chat box: https://qppsupport.org/Events/Archived-Events.aspx.

April Faulkner:

At this time, I would like to introduce our presenter. Denise Walsh is a certified professional coder and has been working in the healthcare industry for over 25 years. As a consultant, her responsibilities range from assisting clients in the creation and implementation of compliance plans, designing and implementing charge capture and coding systems that maximize reimbursement, and reviewing accounts receivable processes to strengthen revenue capture. She provides consulting support in the review and implementation of EHR PM systems, ICD-10, and HIPAA privacy and security and compliance plans for physician practices. She has extensive experience in guiding credentialing and payer contracting for new and established physicians and practices, and lectures extensively on all of these topics. Denise has also served in the capacity of revenue cycle management director and practice administrator for several specialty practices.

April Faulkner:

Denise received her B.S. Degree in Allied Medicine from Ohio State University, and is a member of the American Academy of Professional Coders. Denise is also a certified HIPAA Security Professional. And now, I'll turn the presentation over to Denise to get us started.

Denise Walsh:

Thank you very much, April, for that lovely introduction and thank you all for joining us today. As April said, today's presentation goes over the key 2020 update for CPT®, ICD-10, and HCPCS codes. Today's presentation is going to be a very high-level review of these codes. We're not going to do a real deep dive into all of the updates, because there are quite a few. There are several slides of this presentation that will just be for resources, for resource tools only, because there is so much information to go over. As we go through the webinar, if you have any questions, please put them in the chat box. Hopefully we will be able to get to those by the end of the presentation. If not, we will respond to all questions in the chat box and post them on the website. Next slide, please.

Denise Walsh:

So this is basically our typical disclaimer, letting you know that all the information in this presentation is accurate as of this webinar, as of today's date, that this is for educational purposes only, and not to be used for a legal reference. If you need legal assistance, please contact your attorney. Next slide, please.

Denise Walsh:

So our objectives for today, we are going to look at the changes for the 2020 CPT® ® codes. We are going to look at CPT®, ICD-10 and the HCPCS codes that are new, and changes for 2020. We're going to look at your coding practices, review these new code deletions, the revisions, and the code descriptors. We're going to look and see how these changes will affect your practice and how you go about making and implementing those changes to your practice. We're going to review the 2020 telehealth guidelines during this COVID-19 crisis, and we're going to take a look at the proposed guidelines and the new E/M guidelines for 2021. Next slide, please.

Denise Walsh:

So each year, the AMA releases their CPT® code set updates. For 2020, these went effect on January 1st. They go into effect every year on January 1st. Each year, there are new, revised, and deleted CPT® codes. For 2020, there was 314 new CPT® codes, 76 revised CPT® codes, and 97 deleted CPT® codes. Next slide, please.

Denise Walsh:

In 2020, all sections of the CPT® book had code changes or revisions, except for anesthesia. There were no changes to the CPT® appendices, and there were two modifier revisions. Next slide.

Denise Walsh:

So the AMA releases code changes quarterly, as well as corrections to CPT® and HCPCS codes and guidelines, and posts them on their website. Not all of these changes may appear in the CPT® book and they may not appear until the following year. ICD-10 codes are updated annually, and they go into effect on October 1st every year. CPT®, HCPCS, and ICD-10 code books use symbols to indicate new, revised codes, and reinstated codes. There are also symbols to indicate that a code has been re-sequenced, and a symbol to indicate that a code is telehealth or telemedicine appropriate. Next slide.

Denise Walsh:

So, how do we prepare for these annual updates? The first thing that I always recommend is to have a set of code books. The code books, you should get them every year. A lot of people will use coding software, and the software is great, but the books are a wonderful resource tool. Using CPT® books, you will find there are guidelines, written guidelines, notations, inclusions or exclusions, notes that you may not find online or with coding software. So we always recommend that you have a current set of coding books on hand.

Denise Walsh:

When you get your 2020 set of coding books, the first thing you should do is review the changes, and as I mentioned in the previous slide, codes are marked to let you know which codes have been revised and changed. As you go through the book, highlight these changes, look in the index and the tabular sections for things that are pertinent to your specialty. Create a cheat sheet for these updates, list codes that you must document differently to meet the criteria for that code. Determine how these changes will impact your practice, and that's in every respect: your billing, your coding, and your documentation. Next slide, please.

Denise Walsh:

It's important to review your paperwork yearly – any paperwork or any documentation that has coding information on it, make sure if you are still paper superbills, or if your referral forms have coding information on them, or any type of paper that contains coding information, your charts master – make sure that they are reviewed and updated annually to include the new changes. You need to make sure that you distribute, discuss and review this information with the providers. Not only does the billing staff need to know, but the providers need to know. There are requirements that are billing-related and there are requirements that are documentation-related. This information has to be disseminated to all the appropriate people in the practice.

Denise Walsh:

Make sure that your software has changed, that they have uploaded these updates. If you're not sure of that, speak with your vendor. It's very important to make sure that your EMR and your practice management system are updated on a regular basis, and if these codes – the new CPT® and the new ICD-10 codes – are part of your system. You want to make sure that training on coding and billing for all staff, for any changes, is held on a yearly basis. And again, it's really important to communicate with your payer rep regarding reimbursement. If there are specialty codes that you may have carved out in your contract for your specialty, and there are changes to those codes, you want to make sure that you talk to your insurance reps, that these changes are added to your contract. Or if certain codes that have been carved out in your contract are now deleted, have the new codes then added to your contract. So you want to make sure that you take a look at that from a reimbursement aspect, because it does and it will affect your revenue cycle.

Denise Walsh:

And last, but not least, archive your old books. Many times I go into a practice and ask if they have reference material, are they using coding books, and they always say, "Yes," and they pull out a set of books that are five years old. So it really doesn't help if your books are that old, make sure that you get rid of your old books, have your new books on hand, and only use those new books. Next slide, please.

Denise Walsh:

So we're going to go through each section of the CPT® book and we will address the changes and updates that have been made. We're going to start with E/M because that is the most used section of

the CPT® book. We're going to look at this section particularly, because some of these guidelines have expanded during this COVID crisis, so it is very relevant. We want to make sure that we touch on these.

Denise Walsh:

For evaluation and management, new codes have been added to E/M visits. Those are the 99421 to 99423. The current guidelines state that these are for an established patient. This is a cumulative time period of over seven days. These are digital E/Ms that are initiated by the patient and they must be performed on a HIPAA-compliant platform for communication. Now, this is how these guidelines have been written for this new code set. Although, these guidelines have been expanded during this COVID crisis, and toward the end of the presentation, I will cover more information regarding telehealth, and I will show you how the guidelines have been temporarily expanded. But, how the new codes have been written by the AMA and are in the CPT® manual, this is how they stay currently. Next slide.

Denise Walsh:

So as I said, these are time-based codes. These codes are for online medical evaluations and services that are non-face-to-face encounters originating from the established patient to the provider for evaluation or management of a problem utilizing Internet resources or digital communication. So that can be through your EMR platform or patient portal, or a different type of digital communication. Again, these are time-based, 5 to 10 minutes, 11 to 20, or over 21 minutes. Next slide, please.

Denise Walsh:

With the creation of the new digital codes 99421 to 443, it has eliminated the online E/M service, they have deleted 99444. So, that code is no longer in service. Next slide, please.

Denise Walsh:

There are two additional E/M codes: 99473, and it's used to report calibration of a patient's home blood pressure monitoring device, and 99474, and this is to report a daily review of blood pressure, patient-collected data, and treatment plan or revision-maintenance of your blood pressure regimen. Next slide, please.

Denise Walsh:

CPT® code 99475 has been revised, previously it read "20 minutes or more." It now reads "The first 20 minutes," and it has a new add-on code, CPT® code 99458 to be used for each additional 20 minutes. Next slide.

Denise Walsh:

So we'll go into the integumentary system next. So, guidelines have been changed for intermediate repair and complex repairs in the integumentary system. The term "Undermining" has been defined to identify the work that is being done. "Undermining" refers to the technique that is used to dissect dermal layers of underlying connective tissues. So the intermediate repair and the complex repair now has been revised to greater explain that definition. Next slide, please.

Denise Walsh:

Some of the most significant changes in the integumentary system are in surgical grafting. Multiple new surgical grafting codes have been added. CPT® code 15769 is reported for soft tissue harvested by direct excision. Codes for the harvest of fat by liposuction are reported based on anatomical location and the amount of fat. So add-on codes have now been created to report additional fat harvested. Harvested codes are reported by recipient site, not from the donor site. Next slide.

Denise Walsh:

Codes for the excision of chest wall tumors have been deleted. These codes have been replaced with new codes in a musculoskeletal system, and we will go over those new codes when we get to that system. Next slide.

Denise Walsh:

So now we are in the musculoskeletal system. There are new surgical codes for needle insertion into a muscle without injection, and additional new codes to report three or more muscles. There are six new add-on codes – CPT® 20700 to 20705 have been created to report preparation and insertion of drug delivery devices and removal of devices. These codes should be reported in conjunction with a primary procedure code. Parenthetical notes are included in the CPT® manual to indicate the primary code with which the add-on code can be reported. Next slide.

Denise Walsh:

Still on the musculoskeletal system, we now have the new chest wall excision codes, and these codes will replace the codes that were deleted in the integumentary system. Next slide, please.

Denise Walsh:

We move over to the respiratory system. There are nine nasal sinus endoscopy codes that have been revised and parenthetical notes added for more consistent code description and clarification of use. It is important to refer to the CPT® manual when reporting these procedures. The exclusionary parenthetical notes provide a list of codes that should not be reported when the procedures are performed on the same side. So again, this is a good indication of why it's important to have the reference books on hand to look at those notes, and to see the parenthetical notes that are appropriate for each of these revised CPT® codes. Next slide, please.

Denise Walsh:

We move on to the cardiovascular system. The cardiovascular system has a multitude of updates for 2020. First, we start with codes for pericardiocentesis. There are three codes that have been deleted, and they have been replaced with new codes. There is now one code for pericardiocentesis, and that is 33016, and this includes imaging guidance, and there are three new codes to report pericardial drainage, 33017 to 33019. Next slide.

Denise Walsh:

Still in the cardiovascular system, CPT® code 33275 has been revised, that's for transcatheter removal. And ascending aorta graft code 33860 has been deleted and replaced by two new codes – 33858 and 33859. When the procedure involves aortic dissection, you use 33858. If performed for aortic disease other than dissection, you would use 33859. Next slide, please.

Denise Walsh:

Still on the cardiovascular system, the code for transverse arch graft has been deleted, and has been replaced with CPT® code 33871. The descriptor here has been revised, again, to better describe the service that's being performed. Next slide.

Denise Walsh:

There are two codes that have been added to report endovascular repair of the iliac artery. The descriptors are very long, and so I didn't include the entire description on this slide. This is basically here for reference, but CPT® code 34717 is an add-on code to the primary procedure, and 34718 is endovascular repair of the iliac artery, not associated with placement of the aortoiliac artery endograft at the same session. Next slide, please.

Denise Walsh:

And here's some additional cardiovascular updates. This includes revised, new, and deleted codes for arterial exploration. Next slide.

Denise Walsh:

We move on to the digestive system. CPT® code 43401, transection of the esophagus with repair has been deleted, and codes 46945 and 46946 have been revised. They now include the verbiage, "Without imaging guidance." Next slide, please.

Denise Walsh:

There are new codes for hemorrhoidectomy and preperitoneal pelvic packing. The category 3, temporary code 0249T has been replaced with a new CPT® code. That code is 46948, and this is used to report internal hemorrhoidectomy. Next slide, please.

Denise Walsh:

There is only one change for 2020 in the male genitalia system. CPT® code 54640 has been revised to allow the reporting of hernia repair when this service is performed during the same surgical session. Previously, the code descriptor included, "With or without hernia repair," which contradicted the parenthetical note in the CPT® manual that stated to report hernia repair separately. So, a revision was definitely necessary. Next slide, please.

Denise Walsh:

We're on to the nervous system. The nervous system is another category that has had several updates for 2020. Spinal puncture codes 62270 and 62272 have been revised, and are now primary codes for two new codes that have been created to report spinal puncture with image guidance. Next slide, please.

Denise Walsh:

As you can see on this slide, all CPT® codes in the nerve block family have been revised. The revisions are very minor, and to go into each one of these through this presentation would be a little too much, so if this is in your wheelhouse, or in your specialty, I would recommend looking at the CPT® book, but each of these revisions are very minor in the nerve block family. Next slide, please.

Denise Walsh:

Additional revisions have been made to nerve injection codes. Specific levels have been removed from the descriptions, and three nerve injection codes have also been deleted. Next slide.

Denise Walsh:

The last of the updates for the nervous system include four new codes for nerve injections, destruction, and radiofrequency ablation. Next slide, please.

Denise Walsh:

We move on to eye, ocular adnexa and ear section. CPT® code 66982 has been revised. The descriptor now includes "Without endoscopic cyclophotocoagulation" and new CPT® code 66987 is used to report extracapsular cataract removal with endoscopic cyclophotocoagulation. Next slide, please.

Denise Walsh:

Another revision and new code in this section. Code 66984 has been revised, again, to include, "Without endoscopic cyclophotocoagulation." A new code has been added, 66988, and that to include "With endoscopic cyclophotocoagulation." So again, some of these revisions have just been made to, again, describe the work that is being done, and make it easier to determine which code to be used. Next slide.

Denise Walsh:

We move on to radiology. This section has one of the most updates throughout the book for 2020, so there are quite a few here. We won't get into them in quite as much detail. I will just provide an overview. But the G.I. tract section of radiology has been overhauled, and that's important to know. Two new codes have been added, five codes have been deleted, and multiple codes have been revised. Again, throughout the book, these changes have been made to more clearly describe the work and limit the reporting of additional codes. CPT® code 74022 has been revised to specify that "Two or more views are required for a complete acute abdominal series." CPT® codes 74210 and 74220 have been revised to add "The scout film and delayed images" in the descriptor. Next slide, please.

Denise Walsh:

CPT® code 74230 have been revised to include "A scout film and delayed image." CPT® code 74240 now includes "The scout film" but eliminates "With and without delayed images." And CPT® code 74246 eliminates the verbiage "With a K.U.B." Next slide, please.

Denise Walsh:

Still in radiology, CPT® code 74248 is a new add-on code for G.I. series exams, and four codes have been revised to indicate single- versus double-contrast exams in radiology. Next slide, please.

Denise Walsh:

These radiology codes have all been deleted. Several indicate additional CPT® codes to refer to for these services, but each one of these has been deleted for 2020. Next slide.

Denise Walsh:

There are multiple new codes and revised codes for myocardial imaging for P.E.T. scans. The changes to this code family better describe the imaging that's performed. This slide and the next slide will indicate all of the updates for P.E.T. scan exams. Next slide, please.

Denise Walsh:

And as you can see, again, these are additional P.E.T. scan updates, revisions, and new codes. Next slide.

Denise Walsh:

There are several updates for S.P.E.C.T. exams. S.P.E.C.T. is "Single Photon Emission Computed Tomography" or S.P.E.C.T. imaging in this subsection of radiology. There are several deleted as well as revised codes in this section. Next slide, please.

Denise Walsh:

There are also four new codes for S.P.E.C.T. imaging. Next slide.

Denise Walsh:

And finally, we have three deleted radiopharmaceutical localization codes in radiology. Next slide.

Denise Walsh:

We move on to pathology and laboratory. In this section, new codes have been added to the therapeutic drug assay codes as listed on this slide. Next slide, please.

Denise Walsh:

And due to frequency of use, there are Molecular Pathology Tier 2 codes that have now received Tier 1 codes. This slide is an example of a few of those updates. Next slide, please.

Denise Walsh:

There are many new Proprietary Lab Analysis, or P.L.A. codes in this section. The changes in this subsection of CPT® include 75 new codes, one revised code, and five deletions. There are too many to cover in this presentation, but we just want to let you know that this section of the CPT® book has a tremendous amount of revisions, and if this is your specialty, then I would suggest doing a deeper dive into pathology and lab. Next slide, please.

Denise Walsh:

And we move on to the next section, which is medicine. We have a few updates on vaccine CPT® codes. There is a new vaccine, a flu vaccine code, and a new and a revised meningococcal vaccine code. Next slide, please.

Denise Walsh:

There a few changes to the biofeedback codes. The previous code 90911 has been deleted, and this code has been replaced with 90912, and that is to be used for the first 15 minutes, and then there's an add-on code 90913, to be used for each additional 15 minutes. Next slide, please.

Denise Walsh:

Codes for retinal drawing, CPT® code 92225 and 92226 have been deleted, and they have been replaced with codes 9220 and 92202. Previously, the codes were reported based on initial or subsequent service. The work for these codes has not changed, but the description for the new codes has changed. And again, it just better describes the work that's being performed. Next slide, please.

Denise Walsh:

There are additional updates in the medicine section. We have three revisions, as well as a new code for motor control testing. Next slide, please.

Denise Walsh:

CPT® code 93229 has been deleted for implantable cardiovascular monitoring. A new CPT® code 93356 has been created for myocardial strain imaging. Next slide, please.

Denise Walsh:

We are still in the medicine category. There are four revised codes for ambulatory blood pressure monitoring. Again, these revisions are minor, and they have been revised to more clearly define the services that are being performed. Next slide.

Denise Walsh:

Some of the most significant changes this year are in long-term E.E.G. monitoring, or your sleep studies. This whole subsection has been updated. The four original codes for these procedures have been deleted, and 23 new codes have been added. These 23 new E.E.G. codes will now separately report the professional and technical components for services performed. Guidelines have been revised and new

guidelines have been added, so there has been a major overhaul in this section. And again, this is one of the sections where I would recommend if you're in neurology, to look at these codes, make sure that these new codes have been added to your payer contract if the old codes were something that were carved out, because these CPT® changes are pretty drastic. Next slide, please.

Denise Walsh:

Here are the four original CPT® codes for long-term E.E.G. monitoring that have been deleted. Next slide, please.

Denise Walsh:

These are the new technical components, or technologist work codes, that are to be reported for long-term E.E.G. monitoring. These are CPT® codes 95700 to 95716. Next slide, please.

Denise Walsh:

These technical component codes are broken down into timeframes and how the patient is monitored. So are they unmonitored, is it intermittent monitoring, or is it real-time monitoring? The technical component is determined by a combination of both. Next slide, please.

Denise Walsh:

The new professional component, or physician work codes can be reported now using CPT® codes 95717 to 95726. These codes can be broken down by timeframe, but also with and without video. So on this slide, these are broken down into timeframes from 2 to 12 hours, 12 to 26, and 36 to 60 hours. Next slide, please.

Denise Walsh:

The remaining new professional component CPT® codes for E.E.G., long-term E.E.G.s are reported for 60 to 84 hours, or over 84 hours. And again, both have the option of with or without video. Next slide, please.

Denise Walsh:

Still in the medicine category, CPT® code 98969, online assessment, has been deleted. It has been replaced by three new codes. The new codes are for online digital E/M services provided by a non-physician provider. A non-physician provider can be a speech therapist, occupational therapist, or a licensed clinical social worker. Those are a few examples. These are time-based services, and this is cumulative time over a seven-day period. Next slide, please.

Denise Walsh:

So, we just went through each section of the CPT® book with the updates and revisions, and I know that's quite a lot of information. So I hope the slides are useful and will be a good resource tool for you. I know it's a lot of information. We're going to go over the CPT® modifiers right now. Next slide, please.

Denise Walsh:

Luckily, there have only been two revisions this year for CPT® modifiers. For modifier 50, the guidelines have been revised and now instruct coders not to use bilateral modifier 50 with an add-on code. The guidelines now state "If an additional supplemental procedure is performed bilaterally, you are to report the add-on code twice using modifier RT for right and LT for left modifiers." The other revision is modifier 63, and this modifier was revised to include the medicine section of codes that can be reported when performed on infants weighing less than four kilograms. Next slide, please.

Denise Walsh:

We're going to review this year's ICD-10 updates. Next slide.

Denise Walsh:

So on October 1st, the CDC, or the Centers for Disease Control and Prevention, came out with their 2020 ICD-10 updates. There were 273 new ICD-10 codes, 21 codes were deleted and 30 were revised. This gives us a total of 72,184 ICD-10 codes. Again, I'm not going to go over all of these in this section, I'm just going to highlight the changes for each section of the ICD-10 book. Next slide, please.

Denise Walsh:

Under the diseases of blood section, you can see that there are new codes listed, a deleted code, and a revised code. You will see as we go through each section of the ICD-10 book that most of the deleted codes this year are truncated codes that are no longer usable, and that they have been revised so that the truncated code now requires a fifth or possibly sixth terminal character. So basically, the deleted code is the truncated code that can no longer be used and they are now revised to add greater specificity to that code. Next slide, please.

Denise Walsh:

So for diseases of the ear, you can see that four codes have been deleted, and they have been replaced by one code for "Vertigo of the central origin." So typically, it's the other way around, but in this case, they have deleted the more specific codes and condensed it to one ICD-10 code. Next slide, please.

Denise Walsh:

For the circulatory system we have several new codes. You can see on this slide. Next slide, please.

Denise Walsh:

And again, we continue. There are several new codes, but again, we have deleted and revised codes. And again, for the circulatory system, the deleted codes are two of the truncated codes that have been revised to now require the fifth terminal character. Next slide, please.

Denise Walsh:

So in the section of diseases of the skin, some new codes have been added. There is a whole new family of codes for pressure sores, and some of the codes in this ICD-10 family will also require the fifth or sixth

terminal digit, but they have added a complete section of codes for pressure sores for elbow, back, buttock, hip, ankle, heel, and so on. Next slide, please.

Denise Walsh:

There are three new codes in the genitourinary category. Next slide, please.

Denise Walsh:

As we get into congenital abnormalities, there are a multitude of updates in this section. There are dozens of new codes, as well as nine codes that have been deleted and revised to include the fifth or sixth terminal character. We're going to go through each slide but we're not going to touch on each of them because they're very detailed. But as in this slide, you can see the codes that have been deleted for this year. Next slide, please.

Denise Walsh:

These are the new codes for congenital polyposis. Next slide.

Denise Walsh:

The new ICD-10 codes for congenital metatarsus. Next slide.

Denise Walsh:

And we have even more new congenital abnormality codes. So as I said, there are quite a few updates this year in this category. Next slide, please.

Denise Walsh:

We move on to signs and symptoms and abnormal findings. There are three new ICD-10 codes under signs and symptoms. The deleted code, again, is one that has been revised to now require the fifth terminal digit. Next slide.

Denise Walsh:

We have a few new and deleted codes under injury and poisoning. Next slide, please.

Denise Walsh:

And we have additional new codes for heat stroke. Next slide, please.

Denise Walsh:

We have new codes for external causes and status codes. Next slide, please.

Denise Walsh:

We have new codes for personal history codes. Next slide.

Denise Walsh:

And last, but not least, there are a few new additional revisions from ICD-10. And again, very little has changed to the verbiage, just minor revisions. Next slide, please.

Denise Walsh:

So we've gone through all of the updates for ICD-10, CPT® and HCPCS. We want to touch on telehealth and CPT® ICD-10 codes during this COVID crisis. We've had a lot of updates, and we've had a lot of expansion of guidelines and revision of guidelines during this crisis, so we want to make sure that we just highlight these for you quickly. We'll go through a few slides, but telemedicine is a service delivery model that delivers healthcare through two ways. It's either real-time, interactive audiovisual or it can be what we say "asynchronous," which is a delayed, non-face-to-face communication between a provider and a patient. Next slide, please.

Denise Walsh:

So as I said, CMS has expanded telehealth services for Medicare during this public health emergency. They've broadened access to telehealth services, and they've expanded to allow the use of telephone-only services to be billed. So this is quite a change for CMS. The list you can see on this slide, there is a link to the CMS website. This link will give you a complete list of codes that CMS has deemed billable via telehealth service. Next slide, please.

Denise Walsh:

So there are different types of telemedicine. The first is your basic E/M visit, and that's when a provider would use telecommunication systems between the patient and the provider. This can be virtual, face-to-face, and it can be audiovisual, as well as audio only. Typically, these are audiovisual encounters, and that's how this service was meant to be, and the guidelines initially read as "An audiovisual encounter." But during the COVID crisis, many commercial payers have expanded their guidelines to include audio-only E/M. This does vary among payers, so please verify with your participating insurance plans, who covers these services and who may cover the E/M visits, the audio-only E/M visits. These are outpatient services, these E/Ms 99201 to 205, and these services can be used for both new and established patients. Initially, they were set up just for established patients, but again, these guidelines have been expanded and are for both new and established patients during the crisis. Next slide, please.

Denise Walsh:

Our next type of telehealth visit is a virtual check-in, and for CPT® code G2012, this is a brief check-in with a provider via telephone or other telecommunication device. It's a five-to-ten minute check-in, and it may not be covered by all payers, so again, we recommend that you check with your participating insurances to see what the coverage may be. CPT® code G2010 is a remote evaluation of recorded video or images submitted by an established patient. And that is a non-face-to-face, and this would be an asynchronous telehealth visit where a patient initiates a visit and may send a provider either a video or possibly images for the provider to review. Next slide, please.

Denise Walsh:

So we have e-visits. E-visits, which we discussed earlier in the presentation, are new for 2020. These are codes 99421 to 99423 for non-face-to-face encounters. These originate from an established patient to a provider, and now, under these circumstances, it's typically through the patient portal, but you can use other forms of technology platforms to do these visual, digital visits. These services include communication, prescriptions and lab orders. These services may be by more than one provider during a seven-day period. But again, these are time-based visits, and they are within a seven-day global period. Next slide, please.

Denise Walsh:

So, one of the biggest expansions during this COVID crisis has been telehealth telephone services. Not all of the payers will allow for telephone visits. Some will allow audio-only E/M services. Some will allow these telephone services, the 99441, 99443. Again, check with your payers. It is payer-specific. They are time-based codes, so you need to make sure that your documentation clearly states the amount of time that was spent on the phone with the patient. Next slide, please.

Denise Walsh:

These are the non-physician telephone services. These are for the non-physician providers, as I mentioned before – therapists, speech therapists, and licensed clinical social workers. The telephone services are time-based, and you need to make sure that the documentation meets that amount and indicates the amount of time that was spent on the call. Again, not all payers cover these, so I would highly recommend that you check with your payer, because coverage will vary. Next slide, please.

Denise Walsh:

We're going to go over some of the telehealth ICD-10 codes for this crisis. Next slide, please.

Denise Walsh:

So effective 4/1/2020, there is a new ICD-10 code for confirmed testing for COVID-19 that is U07.1., that is to only be used if it is a confirmed positive for COVID-19. If you are seeing patients and you are testing patients for COVID-19, but you cannot confirm for positive, you are doing it for other reasons then the first would be encounter of, for suspected exposure, or contact with the communicable diseases. Maybe the encounter is for travel health counseling, or for a person whose feared health complaint but no diagnosis has been made yet. So these are acceptable diagnoses to be used for COVID-19 patients. Next slide, please.

Denise Walsh:

So if you were coding ICD-10 for COVID-19 patients, you need to make sure that if the patients are presenting with any signs and symptoms, but don't have a definite diagnosis of COVID, that you are diagnosing those signs and symptoms, such as fever or congestion, or whatever it might be. If they have a condition that is due to COVID, you need to make sure that you are coding the condition, as well as the COVID. The COVID-19 ICD-10 code should be your primary code. So if the patient has pneumonia due to COVID, then you would code the COVID ICD-10U07.1 with the code for pneumonia, J12.89. Same thing

with acute bronchitis. If it was due to COVID, you would use the confirmed COVID diagnosis, the U07.1 with the acute bronchitis code. If the bronchitis is non-specified, you would then use the J40 code. So always remember that if the condition is COVID-related, COVID is your primary diagnosis, and any related condition is secondary. Next slide.

Denise Walsh:

Here are more examples. Lower respiratory infection, again, COVID diagnosis first, and then using the lower respiratory infection, J22, as your secondary. Acute respiratory distress due to COVID, you would use the COVID diagnosis, and then the J80 for acute respiratory distress syndrome. Next slide, please.

Denise Walsh:

I know we're getting close to the end here, so I just want to touch on this. We've gone over a lot of 2020 changes, but I just want you to look ahead for 2021, because there are some new E/M guidelines coming as of January 2021. Next slide, please.

Denise Walsh:

Effective January 1st, there will be changes to office and outpatient CPT® codes – the 99201 to 99215 codes will be revised. The appropriate level of E/M service will now be based on medical decision-making, or the total time of service for that date of encounter. Next slide, please.

Denise Walsh:

These changes for 2021 include CPT® code 99201, which is a new patient level one, will be deleted. Codes will be based on medical decision-making, and since the medical decision-making for a new patient, level one and level two are the same, they are both straightforward, they've decided to delete CPT® code 99201. History and exam components will no longer be part of the equation to determine the level of a CPT® visit, but the exam and the history should still be documented and a medically appropriate history and exam should be done for the patient. Time-based coding includes both face-to-face and non-face-to-face time that is spent by the physician on the day of the encounter. So now time that is spent reviewing notes, reviewing tests, reviewing reports prior to the visit will all count as time towards that encounter. Next slide.

Denise Walsh:

So these 2020 changes include changes with medical decision-making, but the levels of medical decision-making will stay the same. We will have the straightforward, the low-complexity, the moderate-complexity and high-complexity, but the new guidelines will give clearer definition to those medical decision-making sub-components, those being the diagnosis management, the data review, and the risk of complication. So you will have a clearer idea of what the true level of medical decision-making is. Next slide.

Denise Walsh:

So, the proposed change for 2021 is that the level of CPT® will be based on medical decision-making. As I mentioned before, the medical decision-making for a new patient level one is straightforward, and so is

level two. They've eliminated 99201. Because 99211 is a nurse visit and medical decision-making isn't a component of that visit, it doesn't come into play either. That code will still be used, but only basically for nurse visits. So the changes going forward for 2021 are level two visits that will be straightforward medical decision-making, level three will be low complexity, level four moderate complexity, and level five visits will be high complexity. Next slide, please.

Denise Walsh:

So what do you do to get ready for 2021? As always, review the requirements, determine, look at your current documentation to see if there are any gaps. What do you need to do to get your documentation to meet the requirements for the new guidelines? Does your current documentation hold up? Does it meet the guidelines? And will it support the CPT® codes for 2021? Begin educating providers and staff on the new guidelines. Make sure that you talk to your EMR vendors, because if you're using EMR systems that have built-in encoders, the encoder templates will need to change. So you need to make sure that your software is ready for those updates. Look at time-based coding. Test the time elements to determine if it's feasible for your process. And, as always, continue to follow the updates with your local Medicare administrative contractor, Novitas, or whoever it might be, and the AMA for your updates. Always keep informed. The better you're informed, the better you will be prepared moving forward. Next slide.

Denise Walsh:

Here are a few links for resources that will be helpful not only for CPT® codes for updates for 2020, but moving forward into 2021. Next slide.

Denise Walsh:

And we are at the end of our presentation. I know that we asked for questions. If you do have any questions, feel free to put them in the chat box. Unfortunately, we won't be able to get to them today, because, as I said, I knew this was going to be a long presentation, but we will be able to answer your questions and post them on the website.

April Faulkner:

Thank you Denise. As Denise said, we will go ahead and collect those questions, so feel free to submit and we will respond to attendees individually, and then also post them on the website and share them with attendees. But thank you everyone for joining us today. I would like to remind you that when you close out of today's session, you will automatically be directed to a brief evaluation. Please take just a moment to complete it, we greatly appreciate your feedback and comments. Also, please note that registration has opened for the next edition of QPPLive!, and that will be held on Thursday, July 16th. So if you visit the link in the chat box [https://bit.ly/2YvbZLH], you can register for that upcoming webinar. Thank you again for joining us and have a great rest of the day. This session is now concluded.

Quality Insights
Quality Payment Program Support Center

This material was prepared by Quality Insights, the Quality Payment Program-Small Underserved and Rural Support Center for Delaware, New Jersey, Pennsylvania and West Virginia under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number QPP-062520