Surgical Coding Update

ASPS Seminar Cleveland, OH September 22, 2018
CMS Proposed Rule 1693

- Published 7/27/18

- SUMMARY: This major proposed rule addresses changes to the Medicare physician fee schedule (PFS) and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services, as well as changes in the statute.

- DATES: Comment date: To be assured consideration, comments must be received no later than 5 p.m. on September 10, 2018.
In an attempt to make billing for E/M services simpler to document, CMS is suggesting single – fee/payment rates for both new and established office visits.

Here is what CMS is proposing for office based E/M reimbursements for 2019:

New Patient Visits:
- 99202 135.00
- 99203 135.00
- 99204 135.00
- 99205 135.00

Established Patient Visits:
- 99212 93.00
- 99213 93.00
- 99214 93.00
- 99215 93.00
Podiatric Evaluation and Management Services (HCPCS codes GPD0X and GPD1X)

We are proposing to create two HCPCS G-codes, HCPCS codes GPD0X (Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, new patient) and GPD1X (Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, established patient), to describe podiatric evaluation and management services. We are proposing a work RVU of 1.36, a physician time of 28.19 minutes, and direct costs summing to $21.29 for HCPCS code GPD0X, and a work RVU of 0.85, physician time of 21.73 minutes, and direct costs summing to $15.87 for HCPCS code GPD1X. These values are based on the average rate for CPT codes 99201-99203 and CPT codes 99211-99212 respectively, weighted by podiatric volume. For further discussion of proposals relating to these codes, see section II.I of this proposed rule.
In order for payment to reflect the resource costs of podiatric visits, we are also proposing to create two HCPCS G codes:

$102- GPD0X (Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, new patient)

$68- GPD1X (Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, established patient)
"The single payment rate for E/M code levels 2 through 5 would benefit podiatry the most because, due to the nature of most podiatric E/M visits, they tend to bill only level 2 and 3 E/M visits."
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (in millions)</th>
<th>Estimated Potential Impact of Valuing Levels 2-5 Together, Without Additional Adjustments</th>
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<tr>
<td>PODIATRY</td>
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<td>DERMATOLOGY</td>
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<td>PLASTIC SURGERY</td>
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APMA Response to the 2019 CMS Proposed Changes to E/M coding and Reimbursement

• APMA has had very productive conversations with medical societies and other organizations and shared with them language to oppose the podiatry-specific E/M Codes, including:
  • American Academy of Orthopaedic Surgeons, American Orthopaedic Foot and Ankle Society, American Academy of Dermatologists, American College of Rheumatology, American Medical Association (and RUC staff), American Hospital Association, Cleveland Clinic, Alliance for Wound Care Stakeholders, and American Geriatric Society.
  • Many letters were drafted, but we know that AMA RUC and AGS have included our language or similar language in their drafts, and many other organizations have indicated that they have a placeholder in their comment letters to address opposition to the podiatry E/M codes.
APMA Response to the 2019 CMS Proposed Changes to E/M coding and Reimbursement

• APMA is a member of the American Geriatric Society (AGS) led coalition on opposing E/M Codes. The Coalition includes over 40 medical and patient advocacy associations.

• APMA had a call with MedPAC Commissioner Dr. Brian DeBusk on August 28, 2018.

• APMA had a meeting with CMS Deputy Administrator Demetrios Kouzoukas and other CMS officials on August 31, 2018.

• APMA had a meeting with White House Office of Management of Budget Health Official Joe Grogan on September 18, 2018.
APMA Response to the 2019 CMS Proposed Changes to E/M coding and Reimbursement

• APMA has meet with the following Congressional leaders and several have indicated that they will contact CMS to address our concerns:
  • Sen. Bill Cassidy, MD (R-LA)
  • Sen. Pat Roberts (R-KS)
  • Sen. Dean Heller (R-NV)
  • Rep. Peter Roskam (R-IL)
  • Rep. Marsha Blackburn (R-TN)
  • Rep. Michael Burgess (R-TX)
  • Rep. Brad Wenstrup, DPM (R-OH)
  • Rep. Mike Kelly (R-PA)
  • Rep. Brett Guthrie (R-KY)
  • Rep. Diane Black (R-TN)
  • Rep. Julia Brownley (D-CA)
  • Rep. Tim Walberg (R-MI)
Please be advised that direct personal contact has been made with the President’s chief economic advisor Lawrence Kudlow, former Secretary of State and presidential advisor Henry Kissinger, Congressman Peter King, and presidential attorney Rudy Giuliani.

Mr. Kudlow will personally meet with Secretary Aznar to discuss and advocate on behalf of Podiatric profession. Direct phone calls will also be made by the other individuals named above.
APMA Response to the 2019 CMS Proposed Changes to E/M coding and Reimbursement

Additionally, APMA met with:

• House Ways & Means Committee majority and minority staff
• Senate Finance Committee majority staff
• Energy and Commerce majority and minority staff
APMA Response to the 2019 CMS Proposed Changes to E/M coding and Reimbursement

- APMA has signed on to coalition letters calling CMS not to finalize any E/M proposals this year and engage in stakeholders, including letters from the AMA, AGS, and the American College of Rheumatology.

- APMA launched its grassroots campaign, and more than 4,000 podiatrists, 400 podiatric medical students, and 1,900 non-DPMs (patients, family, and friends) have already submitted comments directly to CMS via APMA’s eAdvocacy grassroots portal. Additionally, APMA has generated more than 2,900 letters to Congress. More than half of APMA state components and affiliates have submitted comments.
Many practitioners are not consistently reporting postoperative visits using CPT code **99024**

CMS-

“Given the very small number of postoperative visits reported using CPT code 99024 during 10-day global periods, we are seeking comment on whether or not it might be reasonable to assume that many visits included in the valuation of 10-day global packages are not being furnished, or whether there are alternative explanations for what could be a significant level of underreporting of postoperative visits.”
Dates for New Codes

ICD-10 Codes – October 1st, 2018

CPT Codes - January 1st, 2019
New/Revised CPT Codes
FINE NEEDLE ASPIRATION CHANGES

Change  CPT 10021:
Fine needle aspiration biopsy, without imaging guidance; **first lesion**

CPT code 10022 was deleted and replaced with:

CPT 10004 for each additional lesion
New Codes with **10021** (which is considered the primary procedure) when using Imaging Guidance:

10005 - Fine needle aspiration biopsy, including *ultrasound* guidance; first lesion

10006 - each additional lesion (List separately in addition to code for primary procedure)

10007 - Fine needle aspiration biopsy, including *fluoroscopic* guidance; first lesion

10008 - each additional lesion (List separately in addition to code for primary procedure)

10009 - Fine needle aspiration biopsy, including *CT* guidance; first lesion

10010 - each additional lesion (List separately in addition to code for primary procedure)

10011 - Fine needle aspiration biopsy, including *MR* guidance; first lesion

10012 - each additional lesion (List separately in addition to code for primary procedure)
BIOPSY CODES CHANGED

11100 & 11101 - DELETED

(Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed)
NEW BIOPSY CODES

• **11X02** (*Tangential* biopsy of skin, (eg, shave, scoop, saucerize, curette), single lesion

• **11X03** (*Tangential* biopsy of skin, (eg, shave, scoop, saucerize, curette), each separate/additional lesion)
NEW BIOPSY CODES

• **11X04** *(Punch biopsy of skin, (including simple closure when performed), single lesion)*

• **11X05** *(Punch biopsy of skin, (including simple closure when performed), each separate/additional lesion)*
NEW BIOPSY CODES

• 11X06 (*Incisional* biopsy of skin (eg, wedge), (including simple closure when performed), single lesion)

• 11X07 (*Incisional* biopsy of skin (eg, wedge), (including simple closure when performed), each separate/additional lesion)
Language added to intro for:
Application of Skin Substitute Graft codes
(15271 - 15278)

This was added to intro:

“Application of non-graft wound dressings are not separately reportable (eg, gel, powder, ointment, foam, liquid) or injected skin substitutes”
CPT 20005 IS DELETED

Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)
New language in strapping section:

*Do not report 29540 in conjunction with 29580, 29581, (for the same extremity)

*Do not report 29580 in conjunction with 29540, 29581, (for the same extremity)

*Do not report 29581 in conjunction with 29540, 29580, (for the same extremity)

For reference:

• 29540 - strapping, ankle and/or foot

• 29580- Unna boot

• 29581 - Application of multi-layer compression system; leg (below knee), including ankle and foot
Change in the description of HOME E/M visits:

The codes 9934X are used to report evaluation and management services provided in a home.

New Language:

Home may be defined as a private residence, temporary lodging, or short term accommodation (eg, hotel, campground, hostel, or cruise ship).
Change to 99446:

- Interprofessional telephone/Internet/electronic health record 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
New Virtual Care Codes

• 994X6 - 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

• 994X0X - Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes
For an explanation on difference between current telehealth E&M’s vs the new Virtual Care Codes

New Chronic Care Remote Physiologic Monitoring (RPM) Codes

**990X0** - 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

**990X1X** - device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

- To report 990X0, 990X1, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. Code 990X0 may be used to report the set-up and patient education on use of the device(s). Code 990X1 may be used to report supply of the device for daily recording or programmed alert transmissions.
New Chronic Care Remote Physiologic Monitoring (RPM) Codes

994X9 - 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
Change to **77021**:  

- Magnetic resonance imaging guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation
New CPT Category III codes:

**CPT** is divided into three categories of **codes**.

**Category I**: Procedures that are consistent with contemporary medical practice and are widely performed.

**Category II**: Supplementary tracking **codes** that can be used for performance measures.

**Category III**: Temporary **codes** for emerging technology, services and procedures.
New CPT Category III codes:

- **0054T** - Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)

- **0055T** - Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)
New CPT Category III codes:

Cat III 0101T - Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high energy

• adds designation that it is not for integumentary procedures
New CPT Category III codes:

• 06X1T - Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound

• 06X2T - each additional wound (List separately in addition to code for primary procedure)
New CPT Category III codes:

0335T revised - Insertion of sinus tarsi implant
(was Extra-osseous subtalar joint implant for talotarsal stabilization)

07X3T - Removal of sinus tarsi implant

07X4T - Removal and reinsertion of sinus tarsi implant
New ICD-10 Codes as of October 1st, 2018
New ICD-10 Codes as of October 1st, 2018

F12.23 – Cannabis dependence with withdrawal
F12.93 – Cannabis use, unspecified with withdrawal
G71.00 – Muscular dystrophy, unspecified
G71.01 – Duchenne or Becker muscular dystrophy
G71.09 – Other specified muscular dystrophies
M79.10 – Myalgia, unspecified site
R93.89 – Abnormal findings on diagnostic imaging of other specified body structures
ICD-10 Codes that will now require a 5th character as of October 1st, 2018

• **G71.0** - Muscular dystrophy

• **M79.1** - Myalgia

• **R93.8** - Abnormal findings on diagnostic imaging of other specified body structures

• **T81.4** – Infection following a procedure
New ICD-10 Codes as of October 1\textsuperscript{st}, 2018

- \textbf{T81.40X__} 7+ Infection following a procedure, \textit{unspecified}
- \textbf{T81.41X__} 7+ Infection following a procedure, \textit{superficial incisional} surgical site
- \textbf{T81.42X__} 7+ Infection following a procedure, \textit{deep incisional} surgical site
- \textbf{T81.44X__} 7+ Sepsis following a procedure
- \textbf{T81.49X__} 7+ Infection following a procedure, other surgical site
ICD-10 Codes as of October 1\textsuperscript{st}, 2018

**Revisions:**

**L98.495** Non-pressure chronic ulcer of skin of other sites with muscle involvement without evidence of necrosis

**L98.496** Non-pressure chronic ulcer of skin of other sites with bone involvement without evidence of necrosis

**L98.498** Non-pressure chronic ulcer of skin of other sites with other specified severity
https://www.apmacodingrc.org
CPT Changes 1-1-17
Summary of Bunionectomy Codes

28292 – W/O OSTEOTOMY
28295 – PROXIMAL OSTEOMTOMY
28296 – DISTAL OSTEOTOMY
28297 – METATARSAL CUNEIFORM FUSION
28298 – PHALANGEAL OSTEOTOMY
28299 – DOUBLE OSTEOTOMY
Proper Names

Silver, Keller, McBride, Mayo, Joplin, Mitchell, Lapidus
CPT-28290 Deleted

CPT-28290 Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg, Silver type procedure)
CPT 28292 Revised

Correction, hallux valgus (bunion), with or without sesamoidectomy; Keller, McBride, or Mayo type procedure

Correction, hallux valgus (bunionectomy), with or without sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method
CPT 28292

Medial eminence of metatarsal bone

Before

Degenerative joint disease

Medial eminence of metatarsal bone

Before

Kirschner wire holding joint

After

After
CPT 28293 Deleted

CPT 28293 Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant

See CPT 28291
CPT 28294 Deleted

CPT-28294 Correction, hallux valgus (bunion), with or without sesamoidectomy; with tendon transplants (e.g., Joplin type procedure)
CPT 28296 Revised

CPT 28296—Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, chevron, or concentric type procedure)

CPT 28296 Correction, hallux valgus (bunionectomy), with or without sesamoidectomy, when performed; with distal metatarsal osteotomy, any method
CPT 28298 Revised

**CPT 28298** Correction, hallux valgus (bunion), with or without sesamoidectomy; by phalangeal osteotomy

**CPT 28298** Correction, hallux valgus (bunionectomy), with or without sesamoidectomy, when performed; with **proximal phalanx osteotomy**, any method
CPT 28299 revised

28299 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

28299 Correction, hallux valgus (bunionectomy), with or without sesamoidectomy, when performed; with **double osteotomy, any method**
CPT 28299

PREOP

Angular deformity of proximal phalanx
Medial eminence of metatarsal bone

POSTOP

Osteotomy proximal phalanx
Osteotomy distal first metatarsal

Note: Internal fixation is not depicted, but would include screw(s), pin(s), wire(s), as needed.
CPT 28299

PREOP

Medial eminence of metatarsal bone

POSTOP

Double osteotomy of the metatarsal with internal fixation

Note: Internal fixation is not depicted, but would include screw(s), pin(s), wire(s), as needed.

Surgical option 2
CPT 28299

PREOP

Angular deformity of proximal phalanx
Medial eminence of metatarsal bone
Angular deformity at the first metatarsal base

POSTOP

Osteotomy proximal phalanx
Osteotomy proximal first metatarsal

Note: Internal fixation is not depicted, but would include screw(s), pin(s), wire(s), as needed.

Surgical option 3
CPT 28740

- Arthrodesis, midtarsal or tarsometatarsal, single joint
CPT 28306

Osteotomy, with or without lengthening, shortening, or angular correction, metatarsal; first metatarsal
CPT 28310

Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
CPT 28289 Revised

28289 — Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint

28289  Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant
Proximal phalanx base with dorsal osteophytes

Distal dorsal metatarsal osteophytes with degenerative changes

Lateral view

Before

Removal of bone

Lateral view

After
CPT 28291  New

28291  Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant
Proximal phalanx base with dorsal osteophytes

Distal dorsal metatarsal osteophytes with degenerative changes

Before

Lateral view

Implant(s)

After

Lateral view
CPT 28295  New

28295  Correction, hallux valgus (bunionectomy), with or without sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method
CPT 28295

Medial eminence of metatarsal bone

High intermetatarsal angle

Osteotomy

Before

After
Hallux Varus Repair
- CPT 28313  Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)

- CPT 28270  Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure)

- CPT 28310  Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)

- CPT 28306  Osteotomy, with or without lengthening, shortening, or angular correction, metatarsal; first metatarsal
Diagnosis Codes for Plantar Plate Injuries

M21.6x- Other acquired deformities of foot
M20.6- Other acquired deformities of toes
M20.4- Other hammer toe(s) acquired
M24.87- Other specific joint derangements of foot, not elsewhere classified
CPT Codes for Plantar Plate Repair

28313- Reconstruction, angular deformity of toe, soft tissue procedures only
28285- Correction, hammertoe
28308- Osteotomy, lessor metatarsal
28270- Capsulotomy; metatarsalphalanageal joint
Bill It All (if you did it)!

28270 – M20.6
28285 -- M20.4
28313 – M24.87
28308 – M21.6x
Hughes’ Rules of Billing

• Don’t bill for anything you didn’t do.

• Don’t do anything that doesn’t need to be done.

• Get paid as much as you can for what you did.