Delivering pragmatic, mid-rev cycle solutions.
Near term wins.
Long term impact.

2024 CPT UPDATES

Natalie Sartori, M Ed, RHIA, CCS,

Learning Objectives

- Review significant CPT code revisions for 2024.
- Identify important guidelines and parenthetical note additions and revisions.
- Review anatomy and other pertinent clinical information important to understanding new CPT codes.

Note: Due to significant code changes and guideline revisions a module published in January will provide a more thorough and detailed review focusing on E/M changes only.

2024 CPT Code Changes

Section	Added	Deleted	Revised
E/M Services	1	0	10
Surgery	23	0	10
Radiology	5	1	0
Pathology and Laboratory	15	1	15
Medicine	43	0	12
Category III	82	32	13
PLA Codes	61	15	10
TOTAL	**230**	**49**	**70**

Evaluation & Management Revisions

Revised:
Guidelines for Selecting Level of Service Based on Time

- Physician(s) and other qualified health care professional(s) may each provide a portion of the face-to-face and non-face-to-face work related to the visit service.
- When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician(s) and other qualified health care professional(s) assessing and managing the patient and/or counseling, educating, communicating results to the patient/family/caregiver on the date of the encounter is summed to define total time.
- Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

New Guideline:
Split or Shared Services

Clarify definition of “substantive portion” of a split (or shared) visit to reflect the revisions to the CPT E/M guidelines.

E/M Selected Using Total Time

- If code selection is based on total time on the date of the encounter, the service is reported by the professional who spent the majority of the face-to-face or non-face-to-face time performing the service.

New Guideline:
Split or Shared Services

E/M Selected Using MDM

- Performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) made or approved the management plan for the **number and complexity of problems addressed at the encounter** and;
- takes responsibility for that plan with its inherent **risk of complications and/or morbidity or mortality of patient management**
- If the **amount and/or complexity of data to be reviewed and analyzed** is used by the physician or other QHP to determine the reported code level, assessing an independent historian's narrative and the ordering or review of tests or documents do not have to be personally performed by the physician or other QHP, because the relevant items would be considered in formulating the management plan.
- Independent interpretation of tests and discussion of management plan or test interpretation must be personally performed by the physician or other QHP if these are used to determine the reported code level by the physician or other QHP.

New Guideline:
Multiple E/M Services on Same Date

- New guidelines to address questions regarding reporting E/M services on same date.
- CPT codes allow reporting two services by the same practitioner on the date of another E/M service, eg, office and inpatient initial, whereas CMS does not.
- The guidelines for multiple E/M services on the same date address circumstances in which the patient has received multiple visits or services from the same physician or other QHP or another physician or other QHP of the exact same specialty and subspecialty who belongs to the same group practice.
- Per day: The hospital inpatient and observation care services and the nursing facility services are “per day” services. When multiple visits occur over the course of a single calendar date in the same setting, a single service is reported. When using MDM for code level selection, use the aggregated MDM over the course of the calendar date. When using time for code level selection, sum the time over the course of the day using the guidelines for reporting time.

Note: these guidelines will be reviewed in more detail in upcoming module that focuses on the E/M revisions for 2024 in January.

New Care Management Codes for Medicare

- Principal Illness Navigation
  - Patient Navigator G0023, G0024
  - Peer Specialist G0140, G0146
- Social determinants of health (SDOH) Risk Assessment (G0136)
- Community Health Integration (SDOH) (G0019, G0022

New Care Management Codes for Medicare

Patient navigation helps people get the health care and other resources they need to be as healthy as possible. Patient navigators work with people, their families, and their caregivers to overcome barriers to cancer screening and diagnosis, cancer care, and resources needed after cancer treatment. Patient barriers may include—

- Lack of transportation.
- Lack of care for children or elderly relatives.
- Not understanding why they should get screened.
- Speaking a language other than English.
- Mistrust of the health care system.
- Fear of finding out they have cancer or fear of the screening procedures.

- A **Certified Peer Specialist (CPS)** is an individual who is trained and certified to provide ongoing support to individuals and their families receiving mental health substance and/or chronic or serious medical diagnoses use recovery supports and services.
- CPSs work from the perspective of their lived experience to help build environments conducive to recovery.
- They promote hope, personal responsibility, empowerment, education, and self-determination in the communities where they serve.
- CPSs are trained to assist others in skill-building, problem-solving, setting up and maintaining self-help mutual support groups, and building self-directed recovery tools.
- A critical role of the CPS is willingness to self-identify their lived experience, using it as a tool for helping others in developing recovery goals and specific steps to reach those goals.

New Care Management Codes

Code	Description
G0023	Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month
+G0024	Principal Illness Navigation services, additional 30 minutes per calendar month

New Care Management Codes Peer Specialist

Code	Description
G0140	Principal Illness Navigation – Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month,
+G0146	Principal Illness Navigation – Peer Support, additional 30 minutes per calendar month

New Care Management Codes
Community Health Integration Services

Code	Description
G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month
+G0022	Community health integration (CHI) services, each additional 30 minutes per calendar month

Community health workers (CHWs) are lay members of the community who work either for pay or as volunteers in association with the local health care system in both urban and rural environments. CHWs usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have been identified by many titles, such as community health advisors, lay health advocates, *promotoras*, outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, help people get the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening

New Care Management Codes

Principal Illness Navigation and Community Health Integration activities are similar and include:

- Conducting assessment or interview to better understand the individual context of the serious, high-risk condition
- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.
- Practitioner, Home, and Community-Based Care Coordination
- Health education
- Building patient self-advocacy skills
- Helping Patient with health care access / health system navigation.
- Facilitating behavioral change as necessary
- Facilitating and providing social and emotional support
- Leverage knowledge of the serious, high-risk condition and/or lived experience

NOTE: The individual activities for code G0023, G0140 and G0019 will be reviewed in further detail

New Care Management Codes
SDOH Risk Assessment

Code	Description
G0136	Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.

Coding Tips:

- This is an assessment, not a screening
- Must use standardized instruments that include food, housing, transportation, utilities
  - more optional
- May use Z codes- not required
- Should have referral or other capacity to address – very general, do not need to be able to do CHI
- Does not need to be same day as the E/M
- See also CPT 96160, 96161 (Patient and caregiver focused health risk assessment

E/M Code Descriptors for Office/Outpatient Visits

Replaced time ranges in 99202-99205 & 99212-99215 with threshold time

CPT Code	2023 Time Range	2024 Minimum Time
99202	15 – 29 minutes	15 minutes
99203	30 – 44 minutes	30 minutes
99204	45 – 59 minutes	45 minutes
99205	60 – 74 minutes	60 minutes
99212	10 – 19 minutes	10 minutes
99213	20 – 29 minutes	20 minutes
99214	30 – 39 minutes	30 minutes
99215	40 – 54 minutes	40 minutes

E/M Code Descriptors for Nursing Facility Codes

Revised times for initial nursing facility code 99306 and subsequent NF code 99308

CPT Code	2023 Minimum Time	2024 Minimum Time
99306	45 minutes	50 minutes
99308	15 minutes	20 minutes

Surgery Section

Musculoskeletal System

Metatarsal Arthrodesis for Bunion Correction (28292 & 28295-28299)

- Clarifies that the corrective measures reported by codes 28292 and 28295-28299 should inherently include removal of the bunion by excision or resection
- Previously, codes 28292 and 28295-28299 did not include language that specified that bunionectomy is required for reporting these codes
- Users mistakenly believed codes in the 28292 code family may be used if a hallux valgus correction has been performed, regardless of whether a bunion was resected or not

Musculoskeletal System

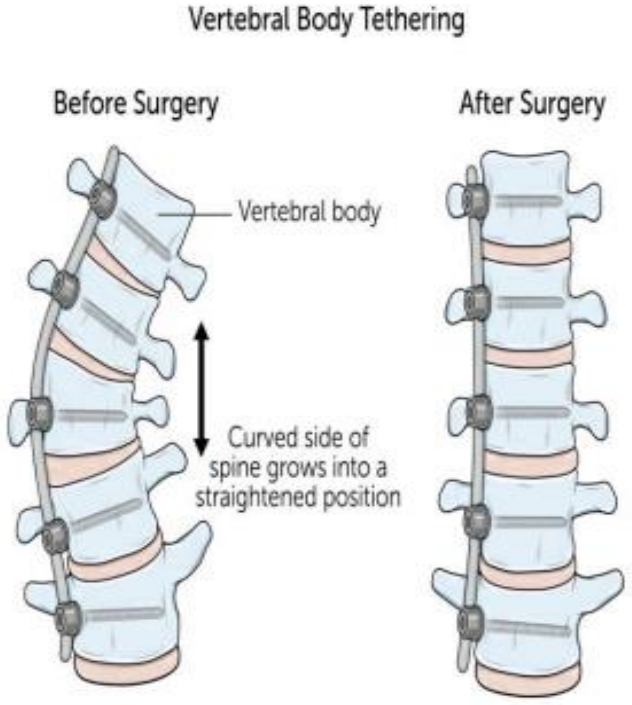
Segmental Spinal Instrumentation

Code	Description	Change
22836	Anterior *thoracic* vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	New
22837	Anterior *thoracic* vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	New
22838	Revision (eg, augmentation, division of tether), replacement, or removal of *thoracic* vertebral body tethering, including thoracoscopy, when performed	New

- Due to increased adoption and utilization of VBT procedures, three codes for anterior thoracic VBT (22836-22838) were added to the code set
- Existing Category III codes (0656T, 0657T) for VBT were revised to clarify that they are limited to the *lumbar or thoracolumbar* spine region
- To match the new Category I code structure, code 0790T was added to report revision, replacement, or removal of thoracolumbar or lumbar VBT

Musculoskeletal System
Segmental Spinal Instrumentation

- Anterior vertebral tethering (AVT), also known as vertebral body tethering (VBT) or, simply, tethering, is a treatment option for patients with severe, progressive scoliosis who are contemplating surgery, but wish to correct their scoliosis without sacrificing growth, motion or function of the spine.
- AVT is an alternative to spinal fusion surgery wherein a flexible cord or “tether” is implanted in the back for gradual scoliosis curve correction. AVT is more physiologic than fusion surgery and avoids the creation of a rigid bone graft in your back. This minimally invasive approach allows endoscopic treatment of thoracic curves and mini-open exposures for lumbar curves.
- Differs from existing procedures in the CPT code set because it does not involve arthrodesis or fusion of the spine



Segmental Spinal Instrumentation – Coding Guidelines/Tips

- Codes 22836, 22837 may not be reported with anterior instrumentation codes 22845, 22846, 22847.
- Do not report 22838 in conjunction with 22849, 22855, 32601
- When two surgeons work together as primary surgeons performing distinct part(s) of the thoracic vertebral body tethering, each surgeon should report his or her distinct operative work by appending modifier 62 to the procedure code. Modifier 62 may be appended to procedure code(s) 22836, 22837, 22838, as long as both surgeons continue to work together as primary surgeons.
- **Guideline parenthetical additions and revision have been added.**

Musculoskeletal System

Segmental Spinal Instrumentation – Quick Coding Reference/Tips

	Location	# Segments	Code
Tether placement	Anterior thoracic	1 through 7	22836
Tether placement	Anterior thoracic	8 or more	22837
Tether placement	Anterior lumbar or thoracolumbar	1 through 7	0656T
Tether placement	Anterior lumbar or thoracolumbar	8 or more	0657T
Revision, replacement, or removal	Thoracic	N/A	22838
Revision, replacement, or removal	Lumbar or thoracolumbar	N/A	0790T

Musculoskeletal System

SI Arthrodesis:

Code	Description	Change
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), **without placement of trans-fixation device**	New

- Code 0775T has been deleted in the CPT 2024 code set with the creation of Category I code 27278, Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device.
- With the addition of code 27278 to the CPT 2024 code set, code 0809T has been deleted.
- The AMA has since clarified that to transfix the SI joint, implants must pass through the ilium and go across the SI joint and into the sacrum. This may be achieved via a lateral or posterolateral transiliac approach. There are more than 30 metallic devices cleared by the FDA that use a lateral transiliac "transfixing device" approach, with either a lateral trajectory or a posterolateral trajectory.
- Non-transfixing MIS SI joint procedures include use of dorsally placed intraarticular or interpositional bone allograft products and devices.

Musculoskeletal System – Category III

Insertion of Calcium-Based Implant — Femur

Code	Description	Change
0814T	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral	New

- Previously, no code existed to report this procedure
- Do not report 0814T in conjunction with 26992, 77002

Respiratory System

Endoscopy

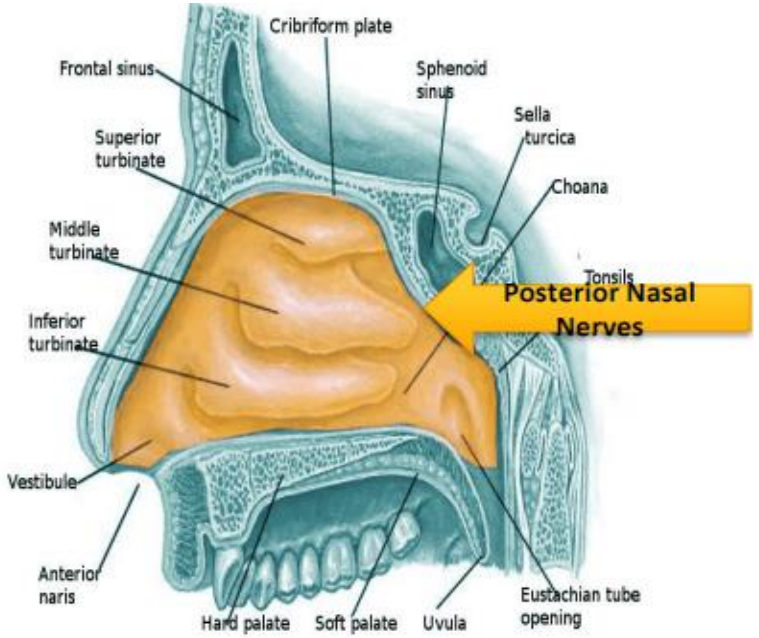
Code	Description	Change
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, **posterior** nasal nerve	New
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, **posterior** nasal nerve	New

- Do not report 31242, 31243 in conjunction with 31231 Diagnostic nasal endoscopy and 92511 Nasopharyngoscopy.
- 31242, 31243 are used to report bilateral procedures. For unilateral procedure, use modifier 52

Respiratory System

Posterior Nasal Nerves:

- Look for documentation that includes posterior nasal sidewall, posterior to middle turbinate or posterior nasal nerves



Cardiovascular System

Phrenic Nerve Stimulation System:

- Codes (33276-33288) have been established to report insertion, removal, repositioning, and replacement of phrenic nerve stimulator system and/or its components
- Services may be used to treat moderate to severe central sleep apnea by stimulation of the phrenic nerve to control breathing.
- Include efforts for insertion (33276, 33277), removal (33278-33280), repositioning (33281), and replacement (33287, 33288) of phrenic nerve stimulation devices or their components which includes a pulse generator (which contains electronics and a battery) and one stimulation lead
- Category III codes 0424T-0436T and all related references have been deleted
- **New guideline language and parenthetical notes have been established to provide instruction on the appropriate reporting.**

Cardiovascular System

Phrenic Nerve Stimulation System

Code	Description	Change
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed	New
+33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)	New
33278	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)	New
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only	New
33280	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only	New

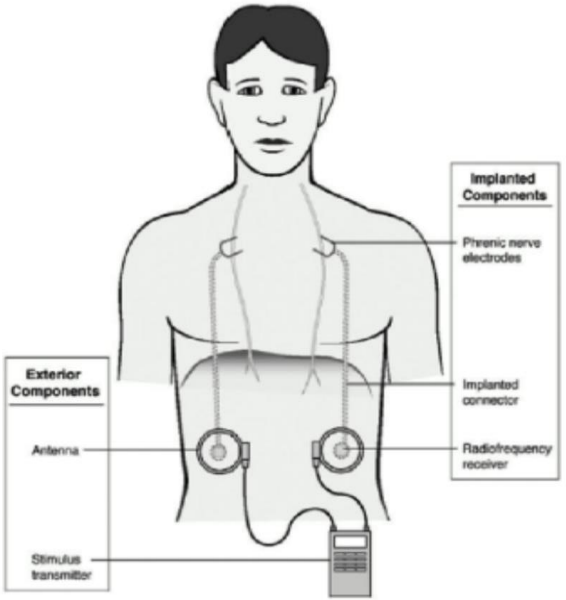
Cardiovascular System

Phrenic Nerve Stimulation System

Code	Description	Change
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	New
33287	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator	New
33288	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s)	New

Cardiovascular System
Phrenic Nerve Stimulation System

- Your body has two phrenic nerves, a left and a right one. Each originates in the neck and passes down between the lung and heart to reach the diaphragm. These nerves play a pivotal part in breathing – passing motor information to the diaphragm while receiving sensory information.
- Phrenic nerve stimulation, also known as diaphragm pacing, is the electrical stimulation of the phrenic nerve using a surgically implanted device. This device contracts the diaphragm rhythmically, improving breathing function in patients with respiratory insufficiency.
- The external transmitter and antennas of the phrenic nerve stimulator send radio frequency energy to the implanted receivers just under the skin. The receivers then convert the radio waves into stimulating pulses. These pulses are then sent down the electrodes to the phrenic nerves, causing the diaphragm to contract. This contraction causes the patient to inhale. When the pulses stop, the diaphragm relaxes and the patient exhales.
- The stimulation lead is placed transvenously into the right brachiocephalic vein or left pericardiophrenic vein.



Phrenic Nerve Stimulation

Therapeutic Activation Services:

- Four new codes (93150-93153), guidelines, and parenthetical instructions have been added within the new subsection of “Phrenic Nerve Stimulation System” located in the Medicine section.
- Codes 93150-93153 identify phrenic nerve stimulation system–therapy activation (93150), interrogation and programming (93151, 93152), and subsequent interrogation only (93153).
- Noted in the guidelines, these codes may be reported when separate programming or interrogation services are required (eg, evaluate device function, incremental performance optimization) and may not be reported for phrenic nerve stimulation system services performed on the same day.
- Code specific guidelines added for new codes.

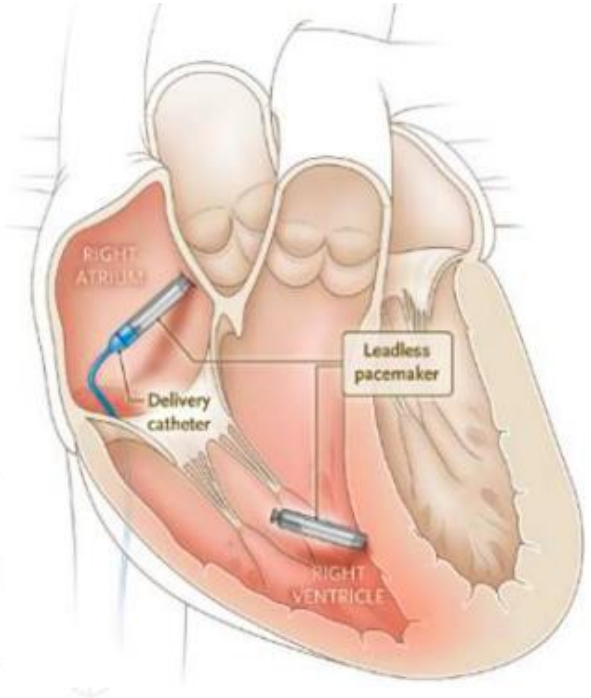
Cardiovascular System - Category III

Dual-Chamber Leadless Pacemakers (0795T-0804T)

- Codes 0795T-0804T allow reporting of transcatheter permanent dual-chamber leadless pacemaker procedures.
- Typically, dual-chamber leadless pacemaker procedures are performed during the same session.
- Code 0797T allows reporting of insertion of a right ventricular leadless pacemaker at an initial session.
- Code 0796T allows reporting of insertion of a right atrial pacemaker at a subsequent session to complete the dual-chamber leadless pacemaker system.
- Device evaluation at the time of leadless pacemaker insertion, replacement, or removal is included
- Do not report 0804T (device evaluation & adjustment) in conjunction with 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T

Dual-Chamber Leadless Pacemakers (0795T-0804T)

- A dual-chamber leadless pacemaker system consisting of two devices implanted percutaneously, one in the right atrium and one in the right ventricle, would make leadless pacemaker therapy a treatment option for a wider range of indications.
- Single-chamber ventricular leadless pacemakers do not support atrial pacing or consistent atrioventricular synchrony.



Cardiovascular System Category III

Dual-Chamber Leadless Pacemakers - Insertion

Code	Description	Change
0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	
0796T	right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system	
0797T	right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	

Cardiovascular System Category III

Dual-Chamber Leadless Pacemakers – Removal

Code	Description	Change
0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	
0799T	right atrial pacemaker component	
0800T	right ventricular pacemaker component (when part of a dual chamber leadless pacemaker system)	

Cardiovascular System Category III

Dual-Chamber Leadless Pacemakers – Removal & Replacement and Evaluation

Code	Description	Change
0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular pacemaker components)	
0802T	right atrial pacemaker component	
0803T	ventricular pacemaker component (when part of a dual chamber leadless pacemaker system)	
0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers	

Urinary System

Transurethral Surgery

Code	Description	Change
52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed	New

- Code 52284 specifically includes cystoscopy, urethral dilation, and drug delivery using a drug-coated balloon catheter.
- Two parenthetical notes have been added in the Surgery/Urethra and Bladder subsection to provide further guidance for reporting this service.
- Do not report 52284 in conjunction with 51610, 52000, 52281, 52283, 74450, 76000

Female Genital System

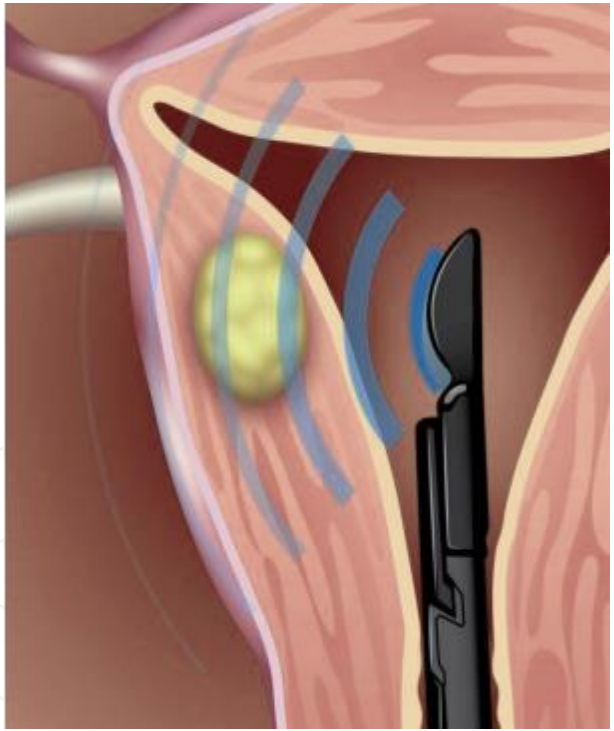
Other Procedures

Code	Description	Change
58580	Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency	New

- Code 0404T (Transcervical uterine fibroid(s) ablation with ultrasound guidance, RF) has been deleted.
- New code 58580 has been established for reporting transcervical RF ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring.
- Do not report 58580 in conjunction with 58561, 58674, 76830, 76940, 76998)
- For laparoscopic radiofrequency ablation of uterine fibroid[s], including intraoperative ultrasound guidance and monitoring, use 58674

Transcervical Ablation of Uterine Fibroid

- Sonata System combines real-time intrauterine ultrasound guidance with targeted radiofrequency ablation in an incisionless procedure to treat symptomatic uterine fibroids.
- An alternative to hysterectomy and myomectomy
- Transcervical delivery avoids the peritoneal cavity and does not require general anesthesia
- Treats most fibroid types including submucous, intramural, transmural, and subserous.



Female Genital System

Other Procedures

Code	Description	Change
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	Revised

- To provide clarity in reporting a parenthetical note has been added to clarify that code 58661 is intended as a unilateral procedure.
- If laparoscopic removal of adnexal structures is performed on both ovaries and/or tubes, the modifier 50 may be applied. This identifies that a bilateral procedure was performed during the same session.
- The term "structures" is meant to identify the partial or total removal of tubes and/or ovaries from one side of the anatomical location

Nervous System System

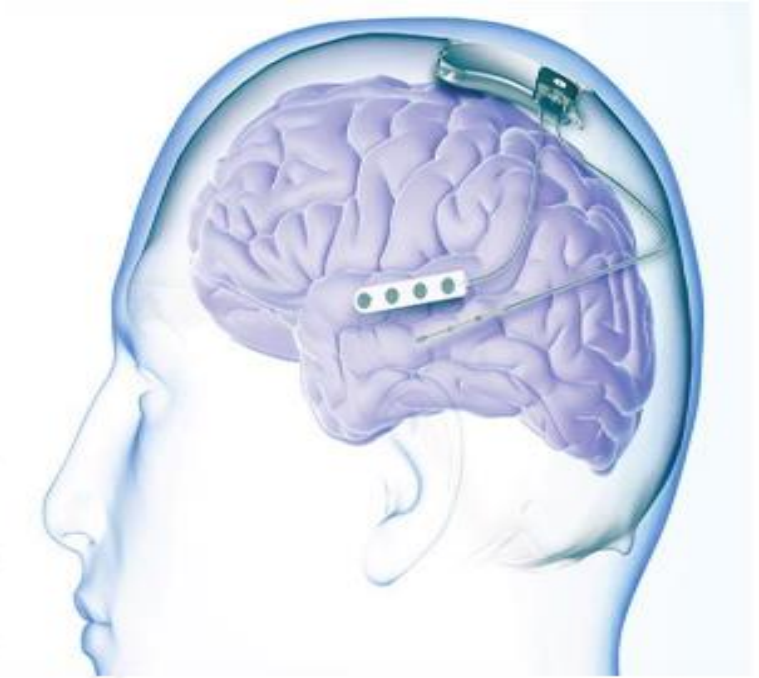
Placement of Cranial Neurostimulator

Code	Description	Change
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	New
61891	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	New
61892	Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed	New

- Guidelines and parenthetical instructions added to aid proper reporting and to distinguish codes 61889-61892 from existing codes 61885-61888 Cranial neurostimulator other then skull mounted.

Nervous System
Placement of Cranial Neurostimulator

- The Responsive Neurostimulation System (RNS, Neuropace, Mountain View, California) has been proven to be effective at reducing seizures in patients with partial-onset epilepsy. The system incorporates a skull-mounted neurostimulator that requires a cranial incision for replacement.
- Stimulation in response to abnormal EEG patterns



Nervous System

Spinal/Peripheral Neurostimulator Services:

- Guideline and code revisions reflect advances in technology

Pre-2024	2024
63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	Removed: “direct or inductive coupling” Added: “requiring pocket creation and connection between electrode array and pulse generator or receiver”
63688 Revision or removal of implanted spinal neurostimulator pulse generator or receive	Added: “with detachable connection to electrode array”

Nervous System

Open Implantation of Sacral Nerve Neurostimulator Electrode Array

- Guideline and code revisions reflect advances in technology

Pre-2024	2024
64590 Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling	Removed: “direct or inductive coupling” Added: “sacral” “requiring pocket creation and connection between electrode array and pulse generator or receiver”
64595 Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver	Added: “sacral” “with detachable connection to electrode array”

Nervous System

Open Implantation of Sacral Nerve Neurostimulator Electrode Array

Code	Description	Change
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array	New
+64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array (List separately in addition to code for primary procedure)	New
64598	Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator	New

- Parenthetical instructions added to clarify proper reporting

Eye and Ocular Adnexa

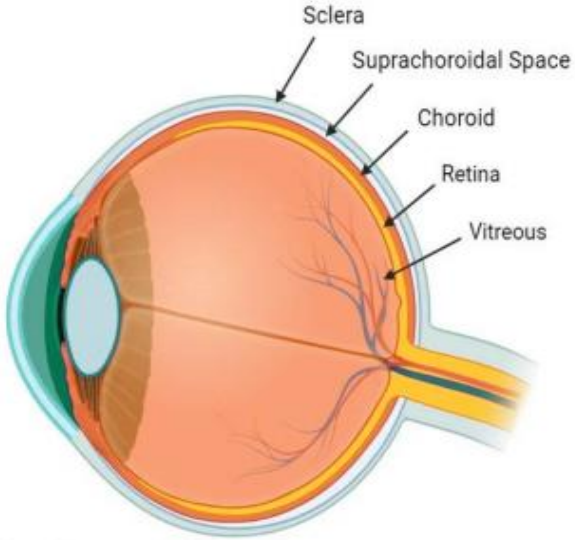
Other Procedures

Code	Description	Change
67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)	New

- Category III code 0465T has been deleted and converted to a new code 67516.
- Code 67516 is used to report the administration of a drug into the suprachoroidal space between the sclera and choroid.
- Report medication separately

Eye and Ocular Adnexa
Suprachoroidal Injection

- Suprachoroidal injection is a novel approach for targeted drug delivery to the posterior segment
- The suprachoroidal space is the region between the sclera and the choroid and provides a potential route for minimally invasive medication delivery.
- Examples of drugs used via suprachoroidal injection to treat age related macular degeneration include ranibizumab and pegaptanib.
- For treatment of diabetic neuropathy, an example is triamcinolone acetonide.



Eye and Ocular Adnexa

Category III Code: Subretinal Drug-delivery Injection

Code	Description	Change
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	New

- Report medication separately
- Do not report 0810T in conjunction with 67036, 67039, 67040, 67041, 67042, 67043

Radiology

Fractional Flow Reserve

New Code:

Code	Description	Guideline
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	Use 75580 only once per coronary computed tomography angiogram

- Code 75580 has been established to report noninvasive estimate of coronary FFR derived from augmentative software analysis of the data set from a CCTA
- Code 75580 includes interpretation and report by a physician or other qualified health care professional.
- When the noninvasive estimate of coronary FFR derived from augmentative software analysis of the data set from a CCTA is performed on the same day as the CCTA, code 75580 may be reported with 75574.

Ultrasound Intraoperative Thoracic Aorta

New Codes:

Code	Description	Guideline
76984	Ultrasound, intraoperative thoracic aorta (eg, epiaortic), diagnostic	For diagnostic intraoperative epicardial cardiac ultrasound [eg, echocardiography], see 76987, 76988, 76989
76897	Intraoperative epicardial cardiac ultrasound (eg, echocardiography) for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report	
76988	placement, manipulation of transducer, and image acquisition only	
76989	interpretation and report only	

- Epicardial echocardiography is performed by placing the ultrasound transducer on the epicardial surface of the heart to acquire 2-dimensional and color flow, and spectral Doppler images in multiple planes.
- Parenthetical notes have been added to provide users with appropriate reporting for these services

Medicine
Vaccines
Toxoids

Vaccines/Toxoids

Other Procedures

Code	Description	Change
90589	Chikungunya virus vaccine, live attenuated, for intramuscular use	New
90623	Meningococcal pentavalent vaccine, conjugated Men A, C, W, Y- tetanus toxoid carrier, and Men B-FHbp, for intramuscular use	New
90683	Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use	New

Medicine

Special Otorhinolaryngologic Services

Code	Description	Change
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes	New
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)	New

Medicine

Cardiovascular:

Code	Description	Change
+92972	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	New

- Deletion of Category III code (0715T) conversion to new Category I code (92972).
- New add-on code 92972 captures additional work of performing percutaneous transluminal coronary lithotripsy in conjunction with other coronary interventional procedures.
- Frequently documented as "Intravascular Lithotripsy (IVL)".
- Used to treat heavily calcified coronary arteries that will not dilate with traditional techniques. An alternative to coronary rotational atherectomy or orbital atherectomy.
- Use 92972 in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975

Medicine

Cardiovascular/ Phrenic Nerve Stimulation System

Code	Description	Change
93150	Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming	New
93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system	New
93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	New
93153	Interrogation without programming of implanted phrenic nerve stimulator system	

Medicine

Congenital Heart Cath Venography Services

- Add-on codes (93584-93588) used for reporting the treatment of congenital heart defects via venography
- Add-on codes 93584, 93585, 93586, 93587, 93588 include selective catheter placement in the specific venous structure(s) being imaged as well as venography and radiologic supervision, interpretation, and report
- Use in addition to procedures performed during heart catheterization for congenital heart defects
- May help to minimize adverse affects of diagnostic procedures, interventional procedures, and open-heart surgery

Medicine

Cardiovascular/ Congenital Cath for Congenital Heart Defects

Code	Description	Change
+93584	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; anomalous or persistent superior vena cava when it exists as a second contralateral superior vena cava, with native drainage to heart	Use 93584 in conjunction with 93593, 93594, 93596, 93597 Report 93584 once per session
+93585	azygos/hemiazygos venous	Use 93584 in conjunction with 93593, 93594, 93596, 93597 Report 93585 once per session
+93586	coronary sinus	Use 93586 in conjunction with 93593, 93594, 93596, 93597 Report 93586 once per session

Medicine

Cardiovascular/ Congenital Cath for Congenital Heart Defects

Code	Description	Change
+93587	Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; venovenous collaterals originating at or above the heart (eg, from innominate vein)	Use 93587 in conjunction with 93593, 93594, 93596, 93597 Report 93587 once per session
+93588	venovenous collaterals originating below the heart (eg, from the inferior vena cava)	(Use 93588 in conjunction with 93593, 93594, 93596, 93597)◀ ▶(Report 93588 once per session)◀

Congenital Cath for Congenital Heart Defects –Terminology

- For coding purposes, the term "**anomalous/persistent left or right SVC" refers to a second SVC on the opposite side of the chest from the first SVC**.
- In a typical cardiac anatomy, the SVC is on the right side and a persistent left SVC would be on the left side. **In situs inversus**, the SVC would typically be located on the left side of the chest and a persistent right SVC would be on the right side. **Situs inversus** is a rare genetic condition in which the organs in your chest and abdomen are positioned in a mirror image of normal human anatomy.
- In **heterotaxy**, bilateral SVCs are common. In these scenarios, venography of the first SVC would be reported with 75827, and catheter placement and venography of the persistent/anomalous SVC would be reported with 93584. **Heterotaxy** is defined as an abnormal arrangement of the internal thoracic-abdominal organs across the left-right axis of the body.

Congenital Cath for Congenital Heart Defects –Terminology

- The **azygos vein** carries blood from the back of your chest and abdomen to your heart. Typically veins form in pairs but azygos vein anatomy is different. Most people have only one azygos vein on the right side of their body. Occasionally, two azygos veins form during fetal development.
- The azygos venous system includes two smaller veins, or tributaries, of the azygos vein: One of these is the **Hemiazygos vein.**
- The **coronary sinus** is the largest vein of the heart. It drains over half of the deoxygenated blood from the heart muscle into the right atrium. It begins on the backside of the heart, in between the left atrium, and left ventricle; it begins at the junction of the great cardiac vein, and oblique vein of the left atrium.
- Small veins that enlarge are called venovenous collaterals. They allow blue blood to bypass the lungs and go directly back to the heart. This may result in cyanosis.

Medicine

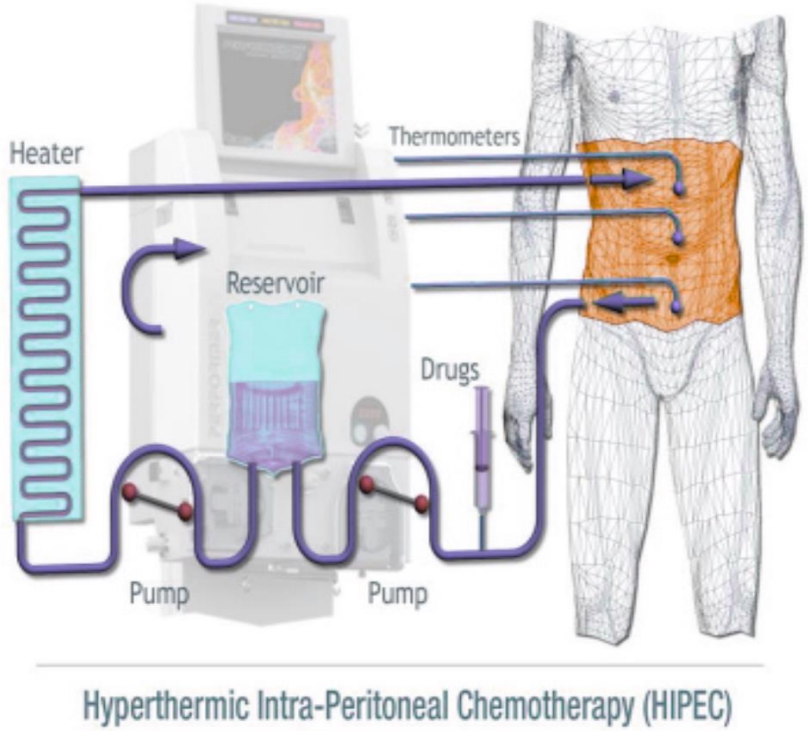
Chemotherapy Administration

Code	Description	Change
+96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)	New
+96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes (List separately in addition to code for primary procedure)	New

- Add-on codes 96547 and 96548 have been introduced to report the time duration of the HIPEC procedure.
- Codes 96547 and 96548 are add-on codes and do not encompass the usual preoperative, intraoperative, and postoperative work associated with the primary procedure.
- New guidelines define the included and excluded work within the HIPEC procedure, when performed.

Medicine
Hyperthermic intraperitoneal chemotherapy (HIPEC)

- Hyperthermic intraperitoneal chemotherapy (HIPEC) surgery is a two-step procedure that treats certain cancers in the abdomen.
- Cancerous tumors are surgically removed, and then heated chemotherapy drugs are applied directly inside the abdomen to eliminate the remaining cancerous cells.



Hyperthermic Intra-Peritoneal Chemotherapy (HIPEC)

Medicine

Modalities – Constant Attendance

Code	Description	Change
97037	Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction	New

Medicine

Caregiver Training without Patient

Code	Description	Change
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes	New
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (List separately in addition to code for primary service)	New
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers	New

Medicine

Pelvic Exam (Practice Expense [PE] Only)

Code	Description	Change
+99459	Pelvic examination (List separately in addition to code for primary procedure)	New

- Use 99459 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397

References

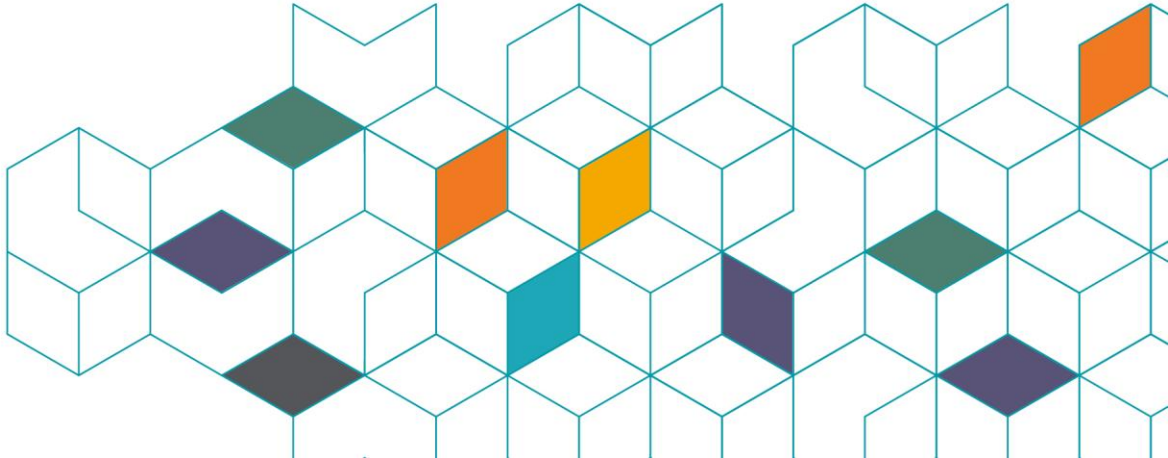
- Examples of SDOH Assessment Tools

Three tools for screening for social determinants of health | AAFP

- Medicare Physician Feel Schedule Final Rule Summary

MM13452 - Medicare Physician Fee Schedule Final Rule Summary: CY 2024 (cms.gov)

Thank you!



UASI

Delivering pragmatic, mid-rev cycle solutions.
Near term wins.
Long term impact.

At a glance

Since 1984, UASI is one of the largest independent healthcare consulting firms in the United States.

A nationally-recognized leader in the mid-revenue cycle field, creating strategies & achieving results for each healthcare client.

39 Years in business

400+ Employees including AHIMA/AAPC-Certified coders, HIM & clinical documentation specialists

200+ Hospitals & Health Systems nationwide

40 Clients in the US News & World Report's Best Regional & Honor Roll Hospitals