CPT: “Reportable” Codes

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The term "reportable" indicates that the service or procedure is considered to be distinct from other services or procedures that are performed, and therefore warrants identification with a separate CPT code. Services or procedures that are considered to be separately reportable but do not have specific CPT code listings may be identified using the appropriate "unlisted" code. If the service or procedure performed is considered to be an integral component of another service or procedure, then separate identification, or reporting, of the procedure would not be appropriate.”

Source: CPT Assistant, February 2002

“Inclusion in the CPT code set does not represent endorsement by the American Medical Association (AMA) of any particular diagnostic or therapeutic procedure or service. Inclusion or exclusion of a procedure or service does not imply any health insurance coverage or reimbursement policy.”


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Physicians’ Current Procedural Terminology ® (CPT) is a listing of descriptive terms and five-digit numeric identifying codes and modifiers for reporting medical services performed by physicians.

This presentation includes only CPT ® descriptive terms, numeric identifying codes, and modifiers for reporting medical services and procedures that were selected by the McKesson Corporation and/or one of its subsidiaries in this product. No fee schedules, basic unit values, relative value guides, guidelines, conversion factors, or scales are included in the Physicians’ Current Procedural Terminology (CPT ®).

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Presentation Agenda

• Code Change Statistics
• New Code Overview & Major Concepts
  – Modifier -96 – synchronous telemed svc via interact audio/video system
  – Modifier –FX – x-ray taken using film
  – New Place of Service codes – ’02’ - The location where health services and health related services are provided or received, through a telecommunication system
  – Moderate Sedation
  – Fluoroscopy Guidance Codes 77002 & 77003 – add-on codes
  – Vaccine code revisions – removed age, replaced with dosage
• New/Revised Coding Review by Organ System
• Question and Answer
Ground Rules for Today’s Presentation

- Not every change in the 2017 CPT Manual will be reviewed;
  - CPT Category 2 and Category 3 codes and changes will not be covered.
  - HCPCS codes and auditing logic will not be covered in detail.

- CMS Medicare Physician Fee Schedule Data Base (MPFSDB)
  - 1st Quarter, 2017, has been incorporated in this KnowledgeBase (KB), utilizing the Non-Facility RVU as the primary criterion for ranking procedures.

- National Correct Coding Initiative (NCCI): Version 23.0
  - 1st Qtr 2017 is considered for sourcing edits in this KB update.

- Specialty Society Sourcing References
  - Specific Specialty Society references (e.g. AAOS 2017) were not available in time for the preparation of this presentation
  - The 2016 American College of Surgery “Assistants at Surgery” report is used as a guide, where appropriate, for “similar service” Asst Surgeon logic
Code Change Statistics
Coding Changes for 2017: CPT

CPT Category I

• New = 94
  – Anesthesia = 0
  – E/M = 0
  – Surgical = 49
  – Radiology = 4
  – Lab = 11
  – Medicine = 30
• Revised = 65
• Deleted = 63

CPT Modifiers

• New = 1 (mod-95)
• Deleted = 0

CPT Category III

• New = 23
• Revised = 8
• Deleted = 18

CPT Category II (xxxxF codes)

• No new, revised or deleted codes
Coding Changes for 2017: HCPCS

HCPCS (new) = 237

- PQRS quality reporting codes = 174
- Highlights:
  - 2 telehealth codes (G0508/G0509)
  - 2 dialysis codes for acute kidney (G0491/G0492)
  - 3 psychiatric collaborative care management codes; first and subsequent month (G0502-G0504)
  - Add-on code for comprehensive assessment and care planning – chronic care management (G0506)
  - Care management for behavioral health condition per calendar month (G0507)
  - Moderate sedation code (G0500) for GI procedures

HCPCS deleted = 139

- PQRS quality reporting codes deleted = 101
### Coding Changes for 2017: HCPCS

**Deleted HCPCS modifier**
- L1 - separately payable lab test

**New HCPCS modifiers (5)**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FX</td>
<td>X-ray taken using film</td>
</tr>
<tr>
<td>PN (existing description since 1996)</td>
<td>Ambulance modifier. Physician office – to – Skilled Nursing Facility</td>
</tr>
<tr>
<td>PN (dual description for 2017)</td>
<td>non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital</td>
</tr>
<tr>
<td>V1</td>
<td>Demonstration Modifier 1</td>
</tr>
<tr>
<td>V2</td>
<td>Demonstration Modifier 2</td>
</tr>
<tr>
<td>V3</td>
<td>Demonstration Modifier 3</td>
</tr>
</tbody>
</table>
ICD-10: Update

A comprehensive review with applicable content updates has been completed as a result of the new and deleted ICD-10-CM code effective for 10/01/2016.

- ICD-10-CM updates to ClaimCheck® ClaimReview PXDX edits will be included in the V59 release

- ICD-10-CM updates were applied in the 4Q 2016 October release for ClaimsXten®
New Code Overview & Major Changes
New Code Overview and Major Concepts

CPT Modifier Update

CPT Modifier-95:

• **Modifier -95** - Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

• Codes that may be used for synchronous telemedicine service are listed in **APPENDIX P**

• These codes are indentified in CPT with the **star (*) symbol**
HCPCS Modifier FX:

- **Modifier -FX** ~ x-ray taken using film
- Modifier will be used on claims that include imaging services that are X-rays (including the imaging portion of a service) taken using film
- The use of this modifier will result in a **20 percent reduction** for the technical portion (TC) of the X-ray service
- CMS has indicated “we believe that physicians and non-physician practitioners are in the best position to determine whether a particular imaging service is an X-ray taken using film”

The McKesson clinical team has identified radiology procedures that are “x-ray” in nature for the modifier-FX reduction

The radiological supervision and interpretation (RS&I) code have been excluded
New Code Overview and Major Concepts
Place of Service Code Update

POS “02”

**CMS Definition:** The location where health services and health related services are provided or received, through a telecommunication system.

- CMS proposes that the **physicians** or **practitioners** furnishing telehealth services would be required to report the telehealth POS code to indicate that the billed service is furnished as a telehealth service from a distant site.

- The POS code for telehealth would **not apply to originating** sites billing the facility fee, the originating site would continue to use the POS code that applies to the type of facility where the patient is located.

- Note: The facility fee for telehealth services is reported using HCPCS code Q3014 (telehealth facility fee)
New Code Overview and Major Concepts
Place of Service “02”

• At this time, Medicare does not allow the beneficiary's home as a covered originating site for telehealth services; however; one exception is the Comprehensive Care for Joint Replacement (CJR) Model, which has specific billing instructions and allows for the beneficiary's home as the originating site.

• The only portion that is considered telehealth services is when the patient was present and interacting with the distant site physician or practitioner.
SUMMARY OF CPT CHANGES:

• Deletion of moderate sedation codes 99143-99145 and 99148-99150

• Addition of new “ADD-ON” codes for moderate sedation codes 99151-99153, 99155-99157

• Now providers who perform moderate sedation with a procedure must report the appropriate new moderate sedation code (99151-99157) to receive full payment.

• It will not be appropriate to report modifier 52 (Reduced services) with a procedure that is not performed with moderate sedation.

• CPT has removed codes from Appendix G as well as removed the moderate sedation symbol on over 425 codes

**99151-99153, 99155-99157:**

- Distinct codes for same physician requiring presence of independent trained observer (99151-99153)
- Distinct codes for other than physician performing service (99155-99157)
- Select code for < 5 yrs or >= 5 yrs old
- Select code for initial 15 minutes –or–
- Each additional 15 minutes
New Code Overview and Major Concepts
Moderate Sedation for GI Procedures

HCPCS New Code G0500

- G0500 represents moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time; patient age 5 years or older

- Additional time may be reported with 99153, as appropriate

CMS “Moderate Sedation Work Values Table” ~ CMS has provided a list of GI procedures appropriately reported with moderate sedation code G0500
New Code Overview and Major Concepts

Fluoroscopic Guidance (77002 & 77003)
Now Add On Codes

77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)

77003 Fluoroscopic guidance for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

- CPT continues with the following guidance ~ “Do not report guidance codes 77001, 77002, 77003 for services with fluoroscopic guidance included in the descriptor”

- CPT has identified the service guidance codes 77002 and 77003 are “Used in conjunction with……” (e.g. fine needle aspiration, introduction or removal procedures in musculoskeletal, respiratory, select biopsy procedures)
Revisions were made to influenza code descriptors that included age specifications to address confusion caused by multiple influenza vaccine products with differing age indications.

- Codes 90655-90658, 90661, and 90685-90688 are revised to include dosage rather than age in their descriptors.
- The descriptor for code 90661 is also revised to include trivalent to differentiate this vaccine from a quadrivalent product.
CPT deletes presumptive drug class screening codes 80300-80304

Replaced with codes 80305-80307

- 80305 direct optical observation
- 80306 instrument assist
- 80307 instrumented chemistry analyzer

✓ The codes include sample validation (such as pH, specific gravity, and nitrite) if performed
✓ The codes apply once per date of service irrespective of the number of direct observation drug class procedures performed or results
# New Code Overview and Major Concepts

Presumptive Class Screening – CPT vs. CMS; CMS Paid

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>ME</th>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Tests, direct optical</td>
<td>80305</td>
<td></td>
<td><strong>G0477</strong></td>
<td>Drug Tests, direct optical</td>
</tr>
<tr>
<td>Drug Tests, instrument-assisted direct optical</td>
<td>80306</td>
<td></td>
<td><strong>G0478</strong></td>
<td>Drug Tests, instrument-assisted direct optical</td>
</tr>
<tr>
<td>Drug Tests, instrumented chemistry analyzers, immunoassay, chromatography &amp; mass spectrometry</td>
<td>80307</td>
<td></td>
<td><strong>G0479</strong></td>
<td>Drug Tests, immunoassay… Drug Tests, thin layer chromatography… Drug Tests, not otherwise specified</td>
</tr>
</tbody>
</table>
Organ System Review
Musculoskeletal System: Spinal Instrumentation

Add-on code **22851** deleted and replaced with three (3) new “add-on” codes to expand on the separate reporting of spinal instrumentation in addition to arthrodesis.

**+22853** Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with **interbody arthrodesis**, each interspace (list separately in addition to code for primary procedure)

**+22854** Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to **vertebral corpectomy(ies)** (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure)

**+22859** Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect **without interbody arthrodesis**, each contiguous defect (list separately in addition to code for primary procedure)
Four (4) new codes for reporting insertion of stabilization or distraction devices at the lumbar level performed without fusion and with or without open decompression.

22867  Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level

+22868  second level (list separately in addition to code for primary procedure)

22869  Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level

+22870  second level (list separately in addition to code for primary procedure)

NOTE: These codes are not to be reported with arthrodesis or laminectomy/ laminotomy procedures performed on the same vertebral level.
Two (2) new codes replacing 27193 and 27194 for more specific reporting of closed treatment of posterior pelvic ring fractures/dislocations with or without anterior pelvic ring fractures/dislocations.

27197 Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation

27198 with manipulation, requiring more than local anesthesia (i.e., general anesthesia, moderate sedation, spinal/epidural)

NOTE: If the treatment involves only anterior pelvic ring fractures/dislocations, CPT directs the use of E&M services codes.
Musculoskeletal System: Foot and Toes

Significant revisions to codes representing hallux rigidus and bunionectomy procedures

• 2 new codes (28291, 28295)
• 3 deleted codes (28290, 28293, 28924)
• 6 revised codes (28289, 28292, 28296, 28297, 28298, 28299)

28289  Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant

28291  with implant (replaces 28293)
Musculoskeletal System: Foot and Toes

28292  Correction, hallux valgus (bunionectomy), with esamoidectomy, when performed; with resection of proximal phalanx base, when performed, *any method (replaces 28290)*

28295  with proximal metatarsal osteotomy, *any method*

28296  with distal metatarsal osteotomy, *any method*

28297  with first metatarsal and medial cuneiform joint arthrodesis, *any method*

28298  with proximal phalanx osteotomy, *any method*

28299  with double osteotomy, *any method (replaces 28294)*
Respiratory System: Accessory Sinuses

Four (4) new codes replacing 31582 to report age-specific laryngoplasty for stenosis **with and without** stent placement

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31551</td>
<td>Laryngoplasty; for laryngeal stenosis, with graft, <strong>without</strong> indwelling stent placement, younger than 12 years of age</td>
</tr>
<tr>
<td>31552</td>
<td>age 12 years or older</td>
</tr>
<tr>
<td>31553</td>
<td><strong>with</strong> indwelling stent placement, younger than 12 years of age</td>
</tr>
<tr>
<td>31554</td>
<td>age 12 years or older</td>
</tr>
</tbody>
</table>

Appropriate age replacement edits will be applied.
Respiratory System: Accessory Sinuses

Three (3) new codes to report additional flexible laryngoscopic procedures performed unilaterally.

31572  Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral

31573  with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral

31574  with injection(s) for augmentation (eg, percutaneous, transoral), unilateral

Two (2) additional laryngeal repair procedures

31591  Laryngoplasty, medialization, unilateral

31592  Cricotracheal resection
Cardiovascular: Heart

Percutaneous left atrial appendage closure (LAAC)

- **33340** – percutaneous transcatheter closure of the left atrial appendage with endocardial implant (McKesson Note: Brand name “watchman”)

Two new options for open aortic valvuloplasty

- **33390 & 33391** – valvuloplasty, aortic valve, open, with cardiopulmonary bypass ~simple/complex

Newborn transfusion

- **36456** – partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified health care professional

Endovenous ablation

- **36473 & 36474** - endovenous ablation therapy of incompetent vein, extremity…percutaneous, mechanochemical; first vein treated/each additional thru separate access sites
Cardiovascular: Dialysis Circuit

Dialysis Circuit (36901 – 36909)

New bundled codes to report dialysis circuit angiography, angioplasty, stent placement, thrombectomy and embolization

New Codes

- Introduction of needle, catheter with (balloon angioplasty/with stent) = 36901-36903
- Percutaneous transluminal mechanical thrombectomy (peripheral & central segment) = 36904-36906
- Add-on codes ~ Balloon angioplasty and stent placement in “central dialysis” segment = 36907-36908
- Add-on code ~ Dialysis circuit permanent vascular embolization = 36909

Codes 35471, 35472, 35475, 35476, 36147, 36148, 36870, and 75791 were deleted for 2017
Cardiovascular: Endovascular Revascularization
Transluminal Balloon Angioplasty (37246-37249)

Unique codes for artery (37246/37248) and vein (37248/37249)

- New Codes includes both angioplasty and radiological supervision & interpretation
- Same Codes Apply to Open and Percutaneous
- Add-On for Each additional Vessel ~ “treated in the same session”

Codes do NOT apply to:

- Dialysis circuit
- lower extremity arteries for occlusive disease
- intracranial, coronary, and pulmonary artery
Two (2) new codes replacing Category III codes 0392T and 0393T to report laparoscopic esophageal sphincter augmentation procedure with placement and subsequent removal of augmentation device (e.g. Linx™)

- **43284** Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (i.e., magnetic band), including cruroplasty when performed
- **43285** Removal of esophageal sphincter augmentation device

New code replacing 0336T to report laparoscopic ablation of uterine fibroids

- **58674** Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency
Nervous System: Injection, Drainage, or Aspiration

Injection Procedures 62320 – 62327 (8 codes)

Deletion of injection codes 62310, 62311, 62318, and 62319 that excluded imaging.

New codes for injection of diagnostic or therapeutic substance:

- Cervical or thoracic, with or without image guidance = 62320, 62321
- Lumbar or sacral, with or without image guidance = 62322, 62323

New code for indwelling catheter placement continuous infusion or intermittent bolus:

- Codes for cervical or thoracic, with or without image guidance = 62324, 62325
- Codes for lumbar or sacral, with or without image guidance = 62326, 62327

NOTE: These codes include imaging may not be reported with fluoroscopy (77003), CT (77012) or ultrasound (76942).
Nervous System: Endoscopic Decompression of Neural Elements and/or Excision of Herniated Discs

Endoscopic Decompression of Spinal Cord

- **62380** - includes laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar

- CPT instructs to report this code bilaterally, use modifier-50

For open procedures, see **63030, 63056**
Radiology:

Ultrasound - screening study for abdominal aortic aneurysm (AAA)

- **76706** – Screening ultrasound of the abdominal aorta for abdominal aortic aneurysm (AAA), real time with image documentation, screening study
- replaced HCPCS code **G0389**

Diagnostic mammography, includes computer-aided detection(CAD) when performed:

- **77065** - unilateral
- **77066** – bilateral

Screening mammography, includes computer-aided detection(CAD) when performed:

- **77067** – bilateral (view study)

Mammography codes **77051, 77052, 77055, 77056, and 77057** have been deleted
Laboratory:

**Tier 1 code:**

**81327** SEPT9 (Septin 9) (eg, colorectal cancer) methylation analysis procedures

**Genomic sequencing/molecular multianalyte:**

**81422** Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); **genomic sequence** analysis panel, must include sequencing of at least **10 genes**, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A

**81423** **Duplication/deletion** gene analysis panel, must include analysis of at least **2 genes**, including KCNH2 and KCNQ1

**81422** Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood

**81439** Inherited cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy) genomic sequence analysis panel, must include sequencing of at least **5 genes**, including DSG2, MYBPC3, MYH7, PKP2, and TTN
Laboratory:

**MAAA**
- **81539** - Oncology (high Grad prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA, and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score

**Chemistry**
- **84410** - testosterone; bioavailable, direct measurement (eg, differential precipitation)

**Microbiology**
- **87483** - infectious agent detection by nucleic acid (DNA or RNA); central nervous system pathogen (eg, neisseria meningitidis, streptococcus pneumoniae, listeria, haemophilus influenzae, e. coli, streptococcus agalactiae, enterovirus, human parechoivirus, herpes simplex virus type 1 and 2, human herpesvirus 6, cytomegalovirus, varicella zoster virus, cryptococcus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets
Three (3) new Vaccine codes have been added:

- **90674** Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use

- **90682** Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use

- **90750** Zoster (shingles) vaccine (HZV), recombinant, sub-unit, adjuvanted, for intramuscular injection
92242 ~ Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral
Medicine: Transcatheter Closure of Paravalvular Leak

93590  Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, **mitral valve**

93591  Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, **aortic valve**

+93592  Percutaneous transcatheter closure of paravalvular leak; **each additional** occlusion device (List separately in addition to code for primary procedure)

Services included when performed:
- percutaneous access, fluoroscopy, angiography, aortography, RS&I, left heart catheterization, diagnostic right heart catheterization
Administration of **patient-focused** health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument

Administration of **caregiver-focused** health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring documentation, per standardized instrument
New code to report application of a small, lightweight, waterproof, battery-powered device placed on the skin of the upper arm or belly to slowly infuse chemotherapy drugs into the body.

**96377** Application of on-body injector (includes cannula insertion) for timed subcutaneous injection
Four (4) new codes replacing 97001, 97002 for more specific reporting of physical therapy evaluations based on the following components:

- History
- Examination
- Clinical decision making
- Development of plan of care

97161  Physical therapy evaluation: low complexity (20 minutes face-to-face)
97162  moderate complexity (30 minutes face-to-face)
97163  high complexity (45 minutes face-to-face)
97164  Re-evaluation of physical therapy established plan of care (20 minutes face-to-face)
Four (4) new codes replacing 97003, 97004 for more specific reporting of occupational therapy evaluations based on the following components:

- Occupational profile and client history (medical and therapy)
- Assessments of occupational performance
- Clinical decision making
- Development of plan of care

*97165*  Occupational therapy evaluation: **low** complexity (30 minutes face-to-face)

*97166*  **moderate** complexity (45 minutes face-to-face)

*97167*  **high** complexity (60 minutes face-to-face)

*97168*  Re-evaluation of occupational therapy established plan of care (30 minutes face-to-face)
Four (4) new codes replacing 97005, 97006 for more specific reporting of athletic training evaluations based on the following components:

- History and physical activity profile
- Examination
- Clinical decision making
- Development of plan of care

97169 Athletic training evaluation: low complexity (15 minutes face-to-face)
97170 moderate complexity (30 minutes face-to-face)
97171 high complexity (45 minutes face-to-face)
97172 Re-evaluation of athletic training established plan of care (20 minutes face-to-face)
Noteworthy editing involving new codes 97161-97164, 97165-97168:

Mutually exclusive edits will be applied when submitted with inpatient E&M services.

- Physical and occupational therapy evaluation services include a patient history and examination performed by a therapist with the development of a plan of care for appropriate rehabilitation methods. In an inpatient setting these evaluations are typically performed by a facility-retained therapist and not the physician providing the E&M service.

- Medicare Claims Processing Manual, Chapter 12, section 30.6.5 states "If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems."
Questions

???
2017 CPT Auditing Logic Update

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• This call is being recorded and the recording will be posted to the MHS Customer Hub where you can access it at any time

• A copy of today’s presentation was provided for download in the reminder e-mail