

Coding, Regulatory & Compliance Update

Cindy C. Parman, CPC, CPC-H, RCC – Coding Strategies Inc
www.codingstrategies.com

Presented March 2015

The material contained in this handout are distributed under copyright by Coding Strategies Inc. Audio or video taping the presentation, taking pictures of slides or copying written handout material is strictly prohibited by this copyright.

Information provided as part of this presentation is not intended to be utilized as consulting advice for an individual practice or facility.

No legal advice is provided as part of this presentation; Coding Strategies recommends that providers review legal issues with healthcare regulatory counsel.

Coding Guidance

Authoritative guidance

- American Medical Association
- American Hospital Association
- Insurance Payors

Opinions

- Specialty Societies
- Other Medical Groups
- Healthcare Consultants
- Billing Companies

Follow your payor guidelines and get it in writing...

Documentation

May 7, 2013: Physicians have turned to time-saving methods, each of which has the potential for abuse leading to the denial of payments...

- Copy-and-paste
- Templates
- Macros
- Pre-built text (Rote Notes)
- Documentation by exception
- “Make me the author” or “Make it mine”

Templates

- Dictation prompts
- ROS or PFSH form

Cloning

- Considerable amount of identically prepared text
- Same or different patient encounters

Program Integrity Manual

5. The PSC and the ZPIC shall determine if patterns and/or trends exist in the medical record which may indicate potential fraud, waste or abuse. Examples include, but are not limited to:

The medical records tend to have obvious or nearly identical documentation;...

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html?DLPage=1&DLSort=0&DLSortDir=ascending>

CMS Transmittal; December 10, 2012

Some templates provide limited options and/or space for the collection of information such as by using “check boxes,” predefined answers, limited space to enter information, etc.

CMS discourages the use of such templates.

Claim review experience shows that that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.

Physicians should be aware that templates designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met.

If a physician chooses to use a template during the patient visit, CMS encourages them to select one that allows for a full and complete collection of information to demonstrate that the applicable coverage and coding criteria are met.

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R455PI.pdf>

2014 OIG Work Plan

Evaluation and Management Services - Inappropriate Payments

Billing and Payments. We will determine the extent to which selected payments for evaluation and management (E/M) services were inappropriate. We will also review multiple E/M services associated with the same providers and beneficiaries to determine the extent to which electronic or paper medical records had documentation vulnerabilities.

Context—Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the billing code for the service on the basis of the content of the service and to have documentation to support the level of service reported.

<http://oig.hhs.gov/reports-and-publications/workplan/index.asp>

OIG Report December 2013

CMS concurs that inappropriate use of the copy-paste feature in EHR technology could increase the risk of fraud, waste and abuse.

CMS will develop appropriate copy-paste guidelines to ensure that this feature is used appropriately for enhancing clinical efficiency.

<http://oig.hhs.gov/oei/reports/oei-01-11-00570.asp>

Modifier 59

59 – Distinct Procedural Service

Indicates that a procedure or service was distinct or independent from other services performed on the same day

Indicates that the ordinarily bundled code represents a service performed independently on the same date

CCI Instructions

The existence of the NCCI edit indicates that the two codes cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations as recognized by coding conventions.

However, if the two corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers generally should not be utilized.

<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/>

Each payor can determine their own bundling guidelines!

New modifiers!!!

Transmittal 1422:

- XE** Separate Encounter; a service that is distinct because it occurred during a separate encounter
- XS** Separate Structure; a service that is distinct because it was performed on a separate organ/structure
- XP** Separate Practitioner; a service that is distinct because it was performed by a different practitioner
- XU** Unusual Non-Overlapping Service; the use of a service that is distinct because it does not overlap the usual components of the main service

MLN Matters SE1503 - January 1, 2015

Please note that providers may continue to use the 59 modifier after January 1, 2015 in any instance in which it was correctly used prior to January 1, 2015.

Additional guidance and education as to the appropriate use of the new X {ESPU} modifiers will be forthcoming as CMS continues to introduce the modifiers in a gradual and controlled fashion.

CR8863 states that providers who wish to use the new modifiers may use them in accordance with their published definitions, and the X modifiers will function within the CMS systems in the same manner as modifier 59.

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1503.pdf>

ASTRO – Choosing Wisely®

- Don't initiate whole breast radiotherapy as a part of breast conservation therapy in women age ≥ 50 with early stage invasive breast cancer without considering shorter treatment schedules.
- Don't initiate management of low-risk prostate cancer without discussing active surveillance.
- Don't routinely use extended fractionation schemes (>10 fractions) for palliation of bone metastases.
- Don't routinely recommend proton beam therapy for prostate cancer outside of a prospective clinical trial or registry.
- Don't routinely use intensity modulated radiation therapy (IMRT) to deliver whole breast radiotherapy as part of breast conservation therapy.
- Don't recommend radiation following hysterectomy for endometrial cancer patients with low-risk disease.
- Don't routinely offer radiation therapy for patients who have resected non-small cell lung cancer (NSCLC), negative margins, N0-1 disease.
- Don't initiate non-curative radiation therapy without defining the goals of treatment with the patient and considering palliative care referral.
- Don't routinely recommend follow-up mammograms more often than annually for women who have had radiotherapy following breast conserving surgery.
- Don't routinely add adjuvant whole brain radiation therapy to stereotactic radiosurgery for limited brain metastases.

<https://www.astro.org/News-and-Media/News-Releases/2013/ASTRO-releases-list-of-five-radiation-oncology-treatments-to-question.aspx>

ASCO – Choosing Wisely®

- Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.
- Don't perform PET, CT and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.
- Don't perform PET, CT and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.
- Don't perform surveillance testing (biomarkers) or imaging (PET, CT and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.
- Don't use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.
- Don't give patients starting on a chemotherapy regimen that has a low or moderate risk of causing nausea and vomiting antiemetic drugs intended for use with a regimen that has a high risk of causing nausea and vomiting.
- Don't use combination chemotherapy (multiple drugs) instead of chemotherapy with one drug when treating an individual for metastatic breast cancer unless the patient needs a rapid response to relieve tumor-related symptoms.
- Avoid using PET or PET-CT scanning as part of routine follow-up care to monitor for a cancer recurrence in asymptomatic patients who have finished initial treatment to eliminate the cancer unless there is high-level evidence that such imaging will change the outcome.
- Don't perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years.
- Don't use a targeted therapy intended for use against a specific genetic aberration unless a patient's tumor cells have a specific biomarker that predicts an effective response to the targeted therapy.

<http://www.asco.org/press-center/new-asco-choosing-wisely%C2%AE-list-details-five-cancer-tests-and-treatments-routinely>

Code Updates

2015 E/M guidelines: Military history added as one of the items included in social history

Advance Care Planning

Codes are used to report the face-to-face service between a physician or other qualified healthcare professional and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.

A “physician or other qualified health care professional” is an individual who is qualified by education, training licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Code	Definition
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms; when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
+99498	...each additional 30 minutes (List separately in addition to code for primary procedure

Can be reported in addition to E/M visit

Advance Care Planning Documentation

- Cognitive evaluation to determine patient’s capacity to understand risks, benefits and alternatives to the advance care planning choices
- Discuss diagnosis, prognosis and patient’s condition
- Review blank advance care directive and physician orders for life-sustaining treatment forms
- Explain and discuss advance directives with patient, family, surrogate
- As appropriate, talk about palliative care options
- Discuss ways to avoid hospital admission/readmission
- Discuss designated agent(s) as substitute decision maker if patient loses decision making capacity (including family dynamics)
- Answer all questions from patient, family member, surrogate

Teletherapy & Brachytherapy isodose plan codes deleted and replaced with new codes for calendar year 2015. These codes are the same in all settings (hospital, freestanding center, physician office).

Deleted codes 77305-77315; replaced with:

Code	Definition
77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculations
77307	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam or special beam considerations), includes basic dosimetry calculations

Deleted codes 77326-77328; replaced with:

Code	Definition
77316	Brachytherapy isodose plan; simple (calculations made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculations
77317	Brachytherapy isodose plan; intermediate (calculations made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculations
77318	Brachytherapy isodose plan; complex (calculations made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculations

Review Changes to Drug Codes

There are a number of changes to HCPCS Level II drug codes for 2015 – watch for minor changes with major impact on reimbursement!

Treatment Delivery – Billed on UB04

Code	Definition
77401	Radiation treatment delivery, superficial and/or orthovoltage, per day
77402	Radiation treatment delivery, ≥ 1 MeV; simple All of the following criteria are met (and none of the complex or intermediate criteria are met): single treatment area, one or two ports and two or fewer simple blocks
77407	Radiation treatment delivery, ≥ 1 MeV; intermediate Any of the following criteria are met (and none of the complex criteria are met): 2 separate treatment areas, 3 or more ports on a single treatment area, or 3 or more simple blocks
77412	Radiation treatment delivery, ≥ 1 MeV; complex Any of the following criteria are met: 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, field-in-field or other tissue compensation that does not meet IMRT guidelines, or electron beam

Freestanding centers may use the same codes as the HOSPITAL for non-Medicare payors...

Code 77401 – New Guidelines

Do not report clinical treatment planning (77261, 77262, 77263), treatment devices (77332, 77333, 77334), isodose planning (77306, 77307, 77316, 77317, 77318), physics consultation (77336), or radiation treatment management (77427, 77431, 77432, 77435, 77469, 77499) with 77401.

When reporting 77401 alone, physician evaluation and management, when performed, may be reported with the appropriate E/M codes.

MPFS Final rule 2015

There is substantial work to be done to assure the new valuations for these codes accurately reflect the coding changes. Accordingly, we are delaying the use of the revised radiation therapy code set until CY 2016 when we will be able to include proposals in the proposed rule for their valuation. According to CMS: All payment policies applicable to the CY 2014 CPT[®] codes will apply to the replacement G codes.

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html>

Treatment Delivery – Billed on CMS1500

2014 Code	2015 Code	Description
76950	G6001	Ultrasonic guidance for placement of radiation therapy fields
77421	G6002	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy
77402	G6003	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV
77403	G6004	...6 – 10 MeV
77404	G6005	...11 – 19 MeV
77406	G6006	...20 MeV or greater
77407	G6007	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV
77408	G6008	...6 – 10 MeV
77409	G6009	...11 – 19 MeV
77411	G6010	...20 MeV or greater
77412	G6011	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV
77413	G6012	...6 – 10 MeV
77414	G6013	...11 – 19 MeV
77416	G6014	...20 MeV or greater
77418	G6015	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session
0073T	G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensators, convergent beam modulated fields, per treatment session
0197T	G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment

IMRT

Hospitals now code:

Code	Definition
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking when performed; simple
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking when performed; complex

Simple:

- Prostate
- Breast
- Compensator-based

Complex:

- All other sites (non-compensator-based)

Freestanding centers code:

2014 Code	2015 Code	Description
77418	G6015	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session
0073T	G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensators, convergent beam modulated fields, per treatment session

Remember – freestanding centers may have to use the new CPT® codes for non-Medicare payors!

Image Guidance

IGRT is used to remove uncertainties in the knowledge of absolute position of the anatomy at the time of delivery, by acquiring volumetric images on the treatment device.

Only one (1) image-guidance code may be charged per treatment session.

Target Localization – Hospital

77387 Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed

- Included in IMRT delivery for hospitals
- Included in IMRT delivery for freestanding centers
- When code accepted by payor
- Professional IGRT billed separately in hospital (multiple codes)
- No change in supervision requirements
- No change in physician review requirements
- Freestanding centers use G codes for Medicare
- Check individual payor guidelines...

Physician/Freestanding Centers code:

2014 Code	2015 Code	Description
77014	77014	CT guidance for placement of radiation therapy fields
76950	G6001	Ultrasonic guidance for placement of radiation therapy fields
77421	G6002	Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy
0197T	G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment

IGRT with IMRT

Because only the technical portion of IGRT is bundled into IMRT, the physician involvement in guidance or tracking may be reported separately in the hospital setting.

3D External Beam

Both the professional and technical component of IGRT can be charged, unless there are individual payor bundling guidelines

Image-guidance is billed in the name of the physician who personally performed the review and approval of the images and/or shifts.

2015 MPFS Final Rule

2015 Estimated Impact Table

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Hematology/Oncology	\$1,811	0%	1%	0%	1%
Radiation Oncology	\$1,794	0%	0%	0%	0%
Radiation Therapy Centers	\$57	0%	0%	0%	1%

*Without considering potential conversion factor change...

Radiation Treatment Vault

Final specialty increases for radiation oncology due to CMS decision to continue to treat the radiation vault as a direct practice expense (for now...). CMS states this requires further study.

Misvalued Codes

Consistent with amendments to the ACA, CMS identifies & reviews potentially misvalued codes

- 77263 – Complex clinical treatment plan
- 77334 – Complex treatment device
- 96372 – Therapeutic injection; SubQ or IM
- 96375 – Therapeutic injection; each add seq IV push new drug
- 96401 – Chemotherapy, SubQ/IM; non-hormonal antineoplastic
- 96409 – Chemotherapy, IV push, initial substance or drug

Identified through a “high expenditure screen”

CMS working with AMA RUC to change the process for reviewing RVUs on new and revised codes

As part of misvalued code initiative:

- CMS will transition all 10-day global codes to 0-day global period in CY 2017
- And transition all 90-day global codes to 0-day global period in CY 2018
- Impacts all intracavitary and interstitial low-dose brachytherapy codes (77761 – 77778)
- Impacts infusion of radioelement (77750)
- May impact brachytherapy apparatus placement codes

HCPCS Codes Not Deleted!

CMS did **NOT** delete HCPCS codes for robotic SBRT (G0339 & G0340).

Off-Campus PBDs

CMS will delete POS 22 (outpatient hospital department) and establish 2 new POS codes:

- One for on-campus outpatient services
- One for off-campus PBD

Required as soon as available (probably about July 1, 2015)

Locum Tenens

CMS has become aware that LTs are being used to fill staffing needs or replace a physician who has left the group. Comments were solicited and CMS will continue to review...

Remove CME From Open Payments

CMS is deleting the Continuing Education Exclusion (also called Continuing Medical Education, or CME) in its entirety.

Eliminating this exemption for payments to speakers at certain accredited or certifying CME events will be more consistent.

2015 OPPS Final Rule

In general, a 2.2% overall increase in OPPS payments. Continues separate payment for 11 designated cancer hospitals.

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html>

Increase Comprehensive-APCs

CMS proposes to make a single payment for all related or adjunctive hospital services provided to a patient in the furnishing of certain primary procedures.

According to the Fr:

We would continue to consider the entire hospital stay, defined as all services reported on the hospital claim reporting the primary service, to be one comprehensive service for the provision of a primary service into which all other services appearing on the claim would be packaged.

This would result in a single Medicare payment and a single beneficiary copayment under the OPPS for the comprehensive service based on all included charges on the claim.

We defined a comprehensive APC (C-APC) as a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service.

Under this policy, we designated each service described by a HCPCS code assigned to a C-APC as the primary service and, with few exceptions, consider all other services reported on a hospital outpatient claim in combination with the primary service to be related to the delivery of the primary service.

Our intent is to capture all of the services associated with the primary service assigned to a C-APC, except those services that would still be separately paid under the OPPTS, even when provided in conjunction with the comprehensive service.

New C-APC for IORT Codes!

77424 Intraoperative radiation treatment delivery, x-ray, single treatment session

77425 Intraoperative radiation treatment delivery, electrons, single treatment session

No separate payment for IORT in 2015

New C-APC for SRS!

Single-session cranial stereotactic radiosurgery (C-APC 0067)

2015 OPPTS Final Rule

Comment: Commenters expressed concern regarding the misalignment between hospitals' billing practices and systems and the proposal to package all services on a claim into the payment for the comprehensive service.

The commenters observed that a significant number of comprehensive service claims spanned more than 5 days, with some claims spanning close to 30 days.

The commenters recommended that CMS limit the payment bundle to services provided within 1 or 2 days of the primary service, or defining the bundle based on episodes of care.

Response: Our intent is to capture all of the services associated with the primary service assigned to a C-APC, except those services that would still be separately paid under the OPPTS, even when provided in conjunction with a comprehensive service.

We believe that it would not be an undue hardship for some hospitals to alter their processes such that they file separate claims for services that are unrelated both clinically and in regard to time to the comprehensive service.

We also do not expect that these claims for comprehensive services in the outpatient setting would extend beyond a few days because the 219 procedures assigned to the 25 C-APCs are almost entirely surgical procedures.

In Summary:

The comprehensive APC payment bundle policy includes all hospital services reported on the claim that are covered under Medicare Part B, except for the excluded services or services requiring separate payment by statute as noted above.

Packaged Services

CMS will conditionally package all ancillary services assigned to APCs with a geometric mean cost of \$100 or less.

Exceptions to the ancillary services packaging policy include preventive services, psychiatry services, and **drug administration services**.

Psychotherapy and related services are excepted because these services are similar to visits and drug administration is excepted because CMS is considering alternatives for drug administration services including the associated add-on codes.

Status indicators

CMS eliminated Status Indicator “X” (ancillary service) and reassign to Q1 (conditionally packaged) or S (significant service).

Proton Beam Therapy

CMS finalized the proposals affecting the proton beam therapy services for CY 2015 as follows:

- CMS reassigned CPT® code 77520 from APC 0664 to APC 0412;
- Deleted APC 0664;
- Reassigned CPT® code 77522 from 0664 to APC 0667;
- Reassigned CPT® codes 77523 and 77525 to APC 0667; and
- Renamed APC 0667 to “Level IV Radiation Therapy.”

Proton Reimbursement Changes

CPT® Code	Descriptor	2014 Final Rule	2015 Final Rule	% Change
77520	Proton treatment, simple without compensation	\$872.37	\$507.55	-41%
77522	Proton treatment, simple with compensation	\$872.37	\$1071.95	21%
77523	Proton treatment, intermediate	\$1205.27	\$1071.95	-12%
77525	Proton treatment, complex	\$1205.27	\$1071.95	-12%

Part B Drugs

CMS will continue paying for ASP + 6% for non-pass-through drugs and biologicals.

The packaging threshold is \$95.

CMS will continue to establish payment rates for blood and blood products using the blood-specific CCR methodology.

Off-Campus PBDs - Hospital

For hospital claims, CMS will create a HCPCS modifier that is to be reported with every code for outpatient hospital services furnished in an off-campus provider-based department.

PO – Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments

2015 OPPS Final Rule

CMS defines the campus as “the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider’s campus.”

Still have questions?

A blue banner with white and yellow text and icons. On the left, a white circle contains the text 'CODINGSTRATEGIES' and 'ICD-10-CM'. To the right, the text 'TRAINING OPTIONS FOR EVERY LEARNER' is displayed above four circular icons: a laptop with a graduation cap, a person with a speech bubble, a book with a pill, and a group of people with a presentation screen. Below the icons, the text 'DESIGN YOUR PLAN @ CODINGSTRATEGIES.COM' is written.

CODINGSTRATEGIES
ICD-10-CM

TRAINING OPTIONS FOR EVERY LEARNER

DESIGN YOUR PLAN @ CODINGSTRATEGIES.COM

www.codingstrategies.com

OPPS Supervision Updates

December 8, 2014 - CMS published a list of therapeutic services that have been evaluated for a change in supervision level.

Medicare requires direct supervision of all hospital outpatient therapeutic services unless CMS makes an assignment of either general or personal supervision for an individual service. There is also a hybrid supervision level for non-surgical extended duration therapeutic services (NSEDTS).

HCPCS Code	Short Descriptor	CMS Decision	Effective Date
C8957	Prolonged IV infusion, requiring pump	NSEDTS	January 1, 2011
36000	Place needle in vein	General	January 1, 2013
36430	Blood transfusion service	General	July 1, 2014
36591	Draw blood implanted venous device	General	January 1, 2013
36592	Collect blood from PICC	General	January 1, 2013
36593	Declot vascular device	General	July 1, 2014
36600	Withdrawal of arterial blood	General	July 1, 2014
96360, 96361	Hydration IV infusion initial hour & each addl hour	General	January 1, 2013
96365, 96367	Therapeutic IV infusion initial hour & 1 st hour new drug	NSEDTS	N/A
96366	Therapeutic IV infusion each additional hour	General	January 1, 2013
96368	Therapeutic concurrent infusion	NSEDTS	N/A
96369, 96371	Subcutaneous therapeutic infusion & reset pump	NSEDTS	N/A
96370	Subcutaneous therapeutic infusion, each addl hour	General	July 1, 2014
96372	Therapeutic subcutaneous or intramuscular injection	General	January 1, 2013
96374, 96375	Therapeutic IV push, initial & each additional drug	NSEDTS	N/A
96376	Therapeutic IV push, same drug	General	January 1, 2013
96401–96417	Chemotherapy administration	Direct	N/A
96521	Refill and maintenance portable pump	General	January 1, 2013
96523	Irrigation of drug delivery device (port flush)	General	January 1, 2013

A complete list of all procedures evaluated to date is located at:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Hospital-Outpatient-Therapeutic-Services-That-Have-Been-Evaluated.pdf>

Code for Lung Cancer Screening

HCPCS Level II Code, effective 10/01/2014:

S0832 Low dose CT for lung cancer screening

<http://www.acr.org/Advocacy/Economics-Health-Policy/Billing-Coding/Coding-Source-List/2014/Mar-Apr-2014/CPT-2015-Anticipated-Code-Chages>

Thank You!



CODINGSTRATEGIES
EXPLORE. EDUCATE. EMPOWER.

Cindy C. Parman | Principal
CPC, CPC-H, RCC, AHIMA Approved ICD-10-CM Trainer

 877.626.3464 x103
 770.445.0407
 cindy.parman@codingstrategies.com
 www.codingstrategies.com



Copyright © 2015, Coding Strategies, Inc.

All rights reserved. No part of this job aid may be reproduced in any form whatsoever without written permission from the publisher. This job aid reflects coding information from the 2015 CPT® Manual. CPT® is a registered trademark of the American Medical Association. CPT® five digit codes, nomenclature and other data are copyright 2014 AMA. All rights reserved. No fee schedules, basic units, relative values or related listings are included in CPT®. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for the data contained herein or not contained herein.

Presented March 2015

19 | Page