Crossroads Health Resources
Coding • Credentialing • Compliance

2024 CPT® Updates With Final Rule Sprinkled In

BRENDA EDWARDS

CPC, CDEO, CPB, CPMA, CPC-I, CEMC, CRC, CPMS, CMRS, CMCS, CPC-RA

DIRECTOR OF AUDITING

What's New

349 editorial changes

230 additions

49 deletions

70 revisions

2024 Code Set *(as of 9/8/2023)*	
Type	**# of codes**
Category I Codes	9,725
Category II Codes	565
Category III Codes	482
PLA Codes	378
MAAA Codes	13
TOTAL	**11,163**

2024 Code Set Sections *(as of 9/8/2023)*	
Type	**# of codes**
Evaluation and Management	157
Anesthesia	276
Surgery	5,860
Radiology Procedures	657
Pathology and Laboratory Procedures	2,031
Medicine Services and Procedures	1,122

11,163 codes that describe the medical procedures and services available to patients

CPT code set continues to grow and evolve with the rapid pace of innovation in medical science and health technology.

SUMMARY - 2024 CPT®/HCPCS CHANGES	ADDED *	DELETED *	REVISED **
Evaluation and Management	1	0	10
Anesthesia	0	0	0
Surgery	23	0	10
Radiology	5	1	0
PathLab	13	0	16
Medicine	21	0	4
	63	**1**	**40**
Category II	0	0	0
Category III	63	32	13
Administrative Codes (MAAA)	0	1	0
PLA Codes	0	0	0
Modifiers	0	0	0
TOTALS	**126**	**34**	**53**

2024 Conversion Factors

	2023	2024
Physician fee schedule conversion factor	$33.8872	$32.75
Anesthesia conversion factor	$21.1249	$20.4349

Changes for 2024 Evaluation & Management Code Set

- E/M code changes are minimal
- CPT® Guideline changes are significant
  - New guidelines for split/shared visits
  - Multiple E/M services on same date

Split/Shared Visits

Physician(s) and other qualified health care professional(s) (QHP[s]) may act as a team in providing care for the patient, working together during a single E/M service. The split or shared visits guidelines are applied to determine which professional may report the service. If the physician/QHP performs a substantive portion of the encounter, the physician/QHP may report the service. 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.

For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s)/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*. By doing so, a physician/QHP has performed two of the three elements used in the selection of the code level based on MDM.

If *the amount and/or complexity of data to be reviewed and analyzed* is used by the physician/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/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/QHP if these are used to determine the reported code level by the physician/QHP.

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Multiple E/M Management Services on Same Date

The following guidelines apply to services that a patient may receive for hospital inpatient care, observation care, or nursing facility care. For instructions regarding transitions to these settings from the office or outpatient, home or residence, or emergency department setting, see guidelines for **Hospital Inpatient and Observation Care Services** or **Nursing Facility Services**.

A patient may receive E/M services in more than one setting on a calendar date. A patient may also have more than one visit in the same setting on a calendar date. 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/QHP or another physician/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.

Multiple E/M Management Services on Same Date

Multiple encounters in different settings or facilities: A patient may be seen and treated in different facilities (eg, a hospital-to-hospital transfer). When more than one primary E/M service is reported and time is used to select the code level for either service, only the time spent providing that individual service may be allocated to the code level selected for reporting that service. No time may be counted twice when reporting more than one E/M service. Prolonged services are also based on the same allocation and their relationship to the primary service. The designation of the facility may be defined by licensure or regulation. Transfer from a hospital bed to a nursing facility bed in a hospital with nursing facility beds is considered as two services in two facilities because there is a discharge from one type of designation to another. An intra-facility transfer for a different level of care (eg, from a routine unit to a critical care unit) does not constitute a new stay, nor does it constitute a transfer to a different facility.

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Multiple E/M Management Services on Same Date

***Emergency department (ED) and services in other settings (same or different facilities)*: Time spent in an ED by a physician/QHP who provides subsequent E/M services may be included in calculating total time on the date of the encounter when ED services are not reported and another E/M service is reported (eg, hospital inpatient and observation care services).**

Discharge services and services in other facilities: Each service may be reported separately as long as any time spent on the discharge service is not counted towards the total time of a subsequent service in which code level selection for the subsequent service is based on time. This includes any hospital inpatient or observation care services (including admission and discharge services) time (99234, 99235, 99236) because these services may be selected based on MDM or time. When these services are reported with another E/M service on the same calendar date, time related to the hospital inpatient or observation care service (including admission and discharge services) may not be used for code selection of the subsequent service.

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Multiple E/M Management Services on Same Date

Discharge services and services in the same facility: If the patient is discharged and readmitted to the same facility on the same calendar date, report a subsequent care service instead of a discharge or initial service. For the purpose of E/M reporting, this is a single stay.

Discharge services and services in a different facility: If the patient is admitted to another facility, for the purpose of E/M reporting this is considered a different stay. Discharge and initial services may be reported as long as time spent on the discharge service is not counted towards the total time of the subsequent service reported when code level selection is based on time.

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Multiple E/M Management Services on Same Date

Critical care services *(including neonatal intensive care services and pediatric and neonatal critical care)*: Reporting guidelines for intensive and critical care services that are performed on the same calendar date as another E/M service are described in the service specific section guidelines.

Transitions between office or other outpatient, home or residence, or emergency department and hospital inpatient or observation or nursing facility: See the guidelines for Hospital Inpatient and Observation Care Services or Nursing Facility Services. If the patient is seen in two settings and only one service is reported, the total time on the date of the encounter or the aggregated MDM is used for determining the level of the single reported service. If prolonged services are reported, use the prolonged services code that is appropriate for the primary service reported, regardless of where the patient was located when the prolonged services time threshold was met. The choice of the primary service is at the discretion of the reporting physician or other QHP.

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The Risk of Complications and/or Morbidity or Mortality of Patient Management

The elements listed in Table 1, Levels of Medical Decision Making, are defined in the guidelines for number and complexity of problems addressed at the encounter, amount and/or complexity of data to be reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management.

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Number & Complexity of Problems Addressed at Encounter

The term “risk” as used in the definition of this element relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

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Parenteral Controlled Substances

The level of risk is based on the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty and subspecialty and not simply based on the presence of an order for parenteral controlled substances.

Risk of Complications and/or Morbidity and/or Mortality of Patient Management

Each service that may be reported using time for code level selection has a required time threshold. The concept of attaining a mid-point between levels does not apply. A full 15 minutes is required to report any unit of prolonged services codes 99417, 99418.

Physician(s)/QHPs may each provide a portion of the face-to-face and non-face-to-face work related to the service. When time is being used to select the appropriate level of services for which time-based reporting is allowed, the time personally spent by the physician(s)/QHPs 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 (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

For split or shared visits, see the split or shared visits guidelines

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What’s New

The CPT editorial panel added revisions to clarify the reporting of evaluation and management services. These include:

The removal of time ranges from office or other outpatient visit codes (99202-99205, 99212-99215) and alignment of the format with other E/M codes.

A definition to determine the "substantive portion" of a split/shared E/M visit when a physician and nonphysician practitioner work together to furnish all the work related to the visit.

Instructions for reporting hospital inpatient or observation care services and admission and discharge services for the use of codes 99234-99236 when the patient stay crosses over two calendar dates.

Updated Language (example)

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using total time on the date of the encounter for code selection, 20~~–29 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.

Clearly stated:

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

Applies to 99202 - 99215

Updated Language

- 99306 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, ~~45~~ 50 minutes must be met or exceeded.

- 99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, ~~15~~ 20 minutes must be met or exceeded.

Pelvic Examination

- #+99459 Pelvic examination (List separately in addition to code for primary procedure)

(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)

Musculoskeletal

- #22836 Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments

(For anterior lumbar or thoracolumbar vertebral body tethering, up to 7 vertebral segments, use 0656T)

- #22837 Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments

(Do not report 22836, 22837 in conjunction with 22845, 22846, 22847, 32601)

(For anterior lumbar or thoracolumbar vertebral body tethering, 8 or more vertebral segments, use 0657T)

- #22838 Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed

(Do not report 22838 in conjunction with 22849, 22855, 32601)

Musculoskeletal - Arthrodesis

Code 27279 describes percutaneous arthrodesis of the sacroiliac joint using a minimally invasive technique to place an internal fixation device(s) that passes through the ilium, across the sacroiliac joint and into the sacrum, thus transfixing the sacroiliac joint. Report 27278 for the percutaneous placement of an intra-articular stabilization device into the sacroiliac joint using a minimally invasive technique that does not transfix the sacroiliac joint.

- 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

(For arthrodesis, sacroiliac joint, with placement of a percutaneous transfixation device, use 27279)

(For bilateral procedure, report 27278 with modifier 50)

Respiratory

- #31242 Nasal/sinus endoscopy, surgical; **with destruction by radiofrequency ablation, posterior nasal nerve**
- #31243 Nasal/sinus endoscopy, surgical; **with destruction by cryoablation, posterior nasal nerve**

(Do not report 31242, 31243 in conjunction with 31231, 92511)

(31242, 31243 are used to report bilateral procedures. For unilateral procedure, use modifier 52)

Cardiovascular
Phrenic Nerve Stimulation System

Insertion of a phrenic nerve stimulation system includes a pulse generator (containing electronics and a battery) and one stimulation lead and is reported with 33276. Pulse generators are placed in a submuscular or subcutaneous “pocket” in the pectoral region. The stimulation lead is placed transvenously into the right brachiocephalic vein or left pericardiophrenic vein. Rarely, a separate sensing lead may be needed to augment system function and, when performed at time of system insertion, is reported with 33277. This sensing lead is placed transvenously into the azygos vein. Initial system placement includes initiation of diagnostic mode and associated system evaluation. Codes 33276, 33277, 33278, 33279, 33280, 33281, 33287, 33288 include vessel catheterization and all imaging guidance required for the procedure, when performed. For therapeutic activation of the phrenic nerve stimulation system, see 93150, 93151, 93152, 93153.

Cardiovascular
Phrenic Nerve Stimulation System

- #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

  (Do not report 33276 in conjunction with 93150, 93151, 93152, 93153)

- #+33277 **Insertion** of phrenic nerve stimulator **transvenous sensing lead** (List separately in addition to code for primary procedure)

  (Use 33277 in conjunction with 33276, 33287)

  (For insertion of a phrenic nerve sensing lead other than at initial insertion of the phrenic nerve stimulator system, use 33999)

Cardiovascular
Phrenic Nerve Stimulation System

- 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)**

- #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**

(Use 33279 once for removal of one or more lead[s])

Cardiovascular
Phrenic Nerve Stimulation System

- #33280 **Removal** of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; **pulse generator only**

  (Do not report 33278, 33279, 33280 in conjunction with 33276, 33277, 33281, 33287, 33288)

- #33281 **Repositioning** of phrenic nerve stimulator transvenous lead(s)

  (Do not report 33281 in conjunction with 33276, 33277)

  (Report 33281 *only once per patient per day*)

Cardiovascular
Phrenic Nerve Stimulation System

- #33287 **Removal and repl**acement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; **pulse generator**

  (Do not report 33287 in conjunction with 33276, 33278)

- #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)**

  (Use 33288 once for removal of one or more lead[s])

  (Do not report 33288 in conjunction with 33277, 33279, 33281)

Genitourinary

- 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

  (Do not report 52284 in conjunction with 51610, 52000, 52281, 52283, 74450, 76000)

- 58580 Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency

  (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)

Neurostimulator

Intracranial

Other than skull-mounted (twist drill, burr hole, craniectomy)

61850-61888

- Skull-Mounted Cranial
  - Insertion 61889
  - Revision/replacement 61891
  - Removal 61892

Spinal

63650 – 63688

- Operative placement, revision, replacement, removal
- Implantation 63650, 63655
- Removal 63661-63662
- Revision 63663-63665
- Replacement 63685-63688

Peripheral Nerve

64553-64598

- Approach 64590, 64596, 64597
- Implant 64553-64566, 64575-64582
- Placement 64590, 64555, 64561,
- Revision/replacement 64569, 64583,
- Revision/removal 64585, 64595, 64598
- Removal 64570, 64584

Analysis and Programming

95970-95982

Neurostimulator – Skull-Mounted

- 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)

  (For insertion of cranial neurostimulator pulse generator or receiver other than skull mounted, see 61885, 61886)

- 61891 Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)

  (For replacement of cranial neurostimulator pulse generator or receiver other than skull mounted, see 61885, 61886)

  (For revision of cranial neurostimulator pulse generator or receiver other than skull mounted, use 61888)

Neurostimulator – Skull-Mounted

- 61892 Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed

  (Do not report 61892 in conjunction with 61891 for the same pulse generator)

  (For removal of cranial neurostimulator pulse generator or receiver other than skull mounted, use 61888)

Neurostimulator

- 64596 Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array
- +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)

(Use 64597 in conjunction with 64596)

(Do not report 64596, 64597 in conjunction with 64555, 64561, 64590, 64595)

(For percutaneous implantation of electrode array only, peripheral nerve, use 64555)

(For implantation of trial or permanent electrode arrays or pulse generators for peripheral subcutaneous field stimulation, use 64999)

(For neurostimulators without a named target nerve [eg, field stimulation], use 64999)

(For percutaneous implantation or replacement of integrated neurostimulation system for bladder dysfunction, posterior tibial nerve, use 0587T)

(For open implantation or replacement of integrated neurostimulator system, posterior tibial nerve, see 0816T, 0817T)

Neurostimulator

- 64598 Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator

(For revision or removal of electrode array only, use 64585)

(For revision or removal of integrated neurostimulation system, posterior tibial nerve, see 0588T, 0818T, 0819T)

Eye and Ocular Adnexa

- 67516 Suprachoroidal space injection of pharmacologic agent (separate procedure)

(Report medication separately)

Radiology

- 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)

  (When noninvasive estimate of coronary 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 is performed on the same day as the coronary computed tomography angiography, use 75580 in conjunction with 75574)

Added Guidance for 75574

- 75574 Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)

  (For 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)

Heart

- 76984 Ultrasound, intraoperative thoracic aorta (eg, epiaortic), diagnostic

  (For diagnostic intraoperative epicardial cardiac ultrasound [ie, echocardiography], see 76987, 76988, 76989)

- 76987 Intraoperative epicardial cardiac ultrasound (ie, 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

  (For diagnostic intraoperative thoracic aorta ultrasound [eg, epiaortic], use 76984)

76000 Guidance Clarification

Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time

(Do not report 76000 in conjunction with 33274, 33275, 33957, 33958, 33959, 33962, 33963, 33964, 0515T, 0516T, 0517T, 0518T, 0519T, 0520T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0823T, 0824T, 0825T, 0861T, 0862T, 0863T)

Genomic Sequencing Procedures (GSP) and Other Molecular Multianalyte Assays

►Code	Specimen Source			Nucleic Acid	Sequence Variants	Copy Number Variants	Microsatellite Instability	Tumor Mutation Burden	Rearrangements
	Hematolymphoid	Solid Organ	Cell-Free						
81445	X		No	DNA or DNA/RNA	X	X			X
81449	X		No	RNA	X				X
81450		X	No	DNA or DNA/RNA	X	X			X
81451		X	No	RNA	X				X
81455	X	X	No	DNA or DNA/RNA	X	X			X
81456	X	X	No	RNA	X				X
81457	X		No	DNA	X		X		
81458	X		No	DNA	X	X	X		
81459	X		No	DNA or DNA/RNA	X	X	X	X	X
81462	X		Yes	DNA or DNA/RNA	X	X			X
81463	X		Yes	DNA	X	X	X		
81464	X		Yes	DNA or DNA/RNA	X	X	X	X	X◄

Pathology and Laboratory

- 81457 Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, microsatellite instability
- 81458 Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, copy number variants and microsatellite instability
- 81459 Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements
- #81462 Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants and rearrangements
- #81463 Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis, copy number variants, and microsatellite instability
- #81464 Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements

Multianalyte Assays with Algorithmic Analyses

- 81517 Liver disease, analysis of 3 biomarkers (hyaluronic acid [HA], procollagen III amino terminal peptide [PIIINP], tissue inhibitor of metalloproteinase 1 [TIMP-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver-related clinical events within 5 years

Chemistry

- 82166 Anti-mullerian hormone (AMH)

Immunology

- #86041 Acetylcholine receptor (AChR); binding antibody
- #86042 Acetylcholine receptor (AChR); blocking antibody
- #86043 Acetylcholine receptor (AChR); modulating antibody
- #86366 Muscle-specific kinase (MuSK) antibody
- 87523 Hepatitis D (delta), quantification, including reverse transcription, when performed
- 87593 Orthopoxvirus (eg, monkeypox virus, cowpox virus, vaccinia virus), amplified probe technique, each

0335U-0419U
Proprietary Clinical Laboratory Analyses (PLA)

61 new “U” codes

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Describe proprietary clinical laboratory analyses and can be either provided by a single (“sole-source”) laboratory or licensed or marketed to multiple providing laboratories (eg, cleared or approved by the Food and Drug Administration [FDA]).

Unless specifically noted, even though the Proprietary Laboratory Analyses section of the code set is located at the end of the Pathology and Laboratory section of the code set, a PLA code does not fulfill Category I code criteria. PLA codes are not required to fulfill the Category I criteria.

The standards for inclusion in the PLA section are:

- The test must be commercially available in the United States for use on human specimens
- The clinical laboratory or manufacturer that offers the test must request the code.

For similar laboratory analyses that fulfill Category I criteria, see codes listed in the numeric 80000 series. *When a PLA code is available to report a given proprietary laboratory service, that PLA code takes precedence.* The service should not be reported with any other CPT code(s) and other CPT code(s) should not be used to report services that may be reported with that specific PLA code.

Codes are released on a quarterly basis to expedite dissemination for reporting.

All codes that are included in this section are also included in Appendix O, with the procedure’s proprietary name.

COVID-19 Vaccines and Administration

- Deletion of over 60 previous codes to streamline reporting of immunizations for COVID-19.
- 6 Provisional replacement codes approved (91318-91322) to identify monovalent vaccine products.
- 90480 vaccine administration reports the administration of *any* COVID-19 vaccine for any patient, *replacing all previously approved product-specific vaccine administration codes.*
- New website established by AMA that will feature timely updates of CPT Panel's actions.
- Appendix Q deleted 11/1/2023 (although in 2024 book).

CPT® Emergency Release COVID Related Code File

New codes for immunizations | Category I and Proprietary Laboratory Analyses (PLA) | CPT® Assistant provides guidance for new codes | Coding advice and testing guides | Related resources | Essential Tools & Resources

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New Current Procedural Terminology (CPT®) codes have been created that streamline the novel coronavirus testing currently available on the United States market.

Find COVID-19 vaccine CPT® codes

Use this AMA tool to determine the appropriate CPT code combination for the type and dose of vaccine being used.

Access Tool

New codes for immunizations

https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-coding-and-guidance

Deleted COVID-19 Codes

Code	Vaccine Code	Vaccine Administration Code(s)	Age Range	Manufacturer
91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted, for intramuscular use	0001A (1st Dose) 0002A (2nd Dose) 0003A (3rd Dose) 0004A (Booster)	12 years and older	Pfizer, Inc
91305	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	0051A (1st Dose) 0052A (2nd Dose) 0053A (3rd Dose) 0054A (Booster)	12 years and older	Pfizer, Inc
91312	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	0121A (1st Dose) 0124A (Additional Dose)	12 years and older	Pfizer, Inc
91307	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris- sucrose formulation, for intramuscular use	0071A (1st Dose) 0072A (2nd Dose) 0073A (3rd Dose) 0074A (Booster)	5 through 11 years	Pfizer, Inc
91315	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	0151A (1st Dose) 0154A (Additional Dose)	5 through 11 years	Pfizer, Inc

Deleted COVID-19 Codes

Code	Vaccine Code	Vaccine Administration Code(s)	Age Range	Manufacturer
91308	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	0081A (1st Dose) 0082A (2nd Dose) 0083A (3rd Dose)	6 months through 4 years	Pfizer, Inc
91317	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	0171A (1st Dose) 0172A (2nd Dose) 0173A (3rd Dose) 0174A (Additional Dose)	6 months through 4 years	Pfizer, Inc
91301	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5 mL dosage, for intramuscular use	0011A (1st Dose) 0012A (2nd Dose) 0013A (3rd Dose)	12 years and older	Moderna, Inc
91306	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, for intramuscular use	0064A (Booster)	18 years and older	Moderna, Inc
91313	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use	0134A (Additional Dose	12 years and older	Moderna, Inc
91314	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use	0141A (1st Dose) 0142A (2nd Dose) 0144A (Additional Dose)	6 months through 11 years	Moderna, Inc
91311	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, spike protein, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use	0111A (1st Dose) 0112A (2nd Dose) 0113A (3rd Dose)	6 months through 5 years	Moderna, Inc
91316	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 10 mcg/0.2 mL dosage, for intramuscular use	0164A (Additional Dose)	6 months through 5 years	Moderna, Inc
91309	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use	0091A (1st Dose) 0092A (2nd Dose) 0093A (3rd Dose)	6 years through 11 years	Moderna, Inc
		0094A (Booster)	18 years and older	
91302	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5 mL dosage, for intramuscular use	0021A (1st Dose) 0022A (2nd Dose)	18 years and older	Astra Zeneca, Plc
91303	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-191) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5 mL dosage, for intramuscular use	0031A (Single Dose) 0034A (Booster)	18 years and older	Janssen
N/A		0041A (1st Dose) 0042A (2nd Dose)	12 years and older	Novavax, Inc
		0044A (Booster)	18 years and older	
91310	Severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, for intramuscular use	0104A (Booster)	18 years and older	Sanofi Pasteur

CPT Code	Long Descriptor	Age Range
90480	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose	
91304	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, ***recombinant*** *spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage,* for intramuscular use	12 years and older
91318	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, *mRNA-LNP,* ***spike protein, 3 mcg/0.2 mL dosage****, tris-sucrose formulation*, for intramuscular use	6 months through 4 years
91319	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, *mRNA-LNP, spike protein,* ***10 mcg/0.2 mL dosage****, tris-sucrose formulation*, for intramuscular use	5 years through 11 years
91320	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, *mRNA-LNP, spike protein,* ***30 mcg/0.3 mL dosage****, tris-sucrose formulation*, for intramuscular use	12 years and older
91321	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, *mRNA-LNP,* ***25 mcg/0.25 mL dosage***, for intramuscular use	6 months through 11 years
91322	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, *mRNA-LNP,* ***50 mcg/0.5 mL dosage***, for intramuscular use	12 years and older

Types of COVID-19 Vaccines

RECOMBINANT VACCINE

Recombinant vaccines are **made using bacterial or yeast cells to manufacture the vaccine**. A small piece of DNA is taken from the virus or bacterium against which we want to protect and inserted into the manufacturing cells.

Recombinant vaccines are protein or DNA recombinants that are inserted into the host cell to trigger immune response.

MESSENGER RNA (MRNA) VACCINES

Unlike conventional vaccines—which can take many months or even years to cultivate—mRNA vaccines can be developed quickly using the pathogen's genetic code.

When an mRNA vaccine is delivered, the RNA material teaches our body how to make a specific type of protein that is unique to the virus, but does not make the person sick.

The protein triggers an immune response, which includes the generation of antibodies that recognize the protein. That way, if a person is ever exposed to that virus in the future, the body would have the tools (antibodies) to fight against it.

Vaccinations

- #⚡90589 Chikungunya virus vaccine, live attenuated, for intramuscular use

- #90611 Smallpox and monkeypox vaccine, attenuated vaccinia virus, live, non-replicating, preservative free, 0.5 mL dosage, suspension, for subcutaneous use

- #90622 Vaccinia (smallpox) virus vaccine, live, lyophilized, 0.3 mL dosage, for percutaneous use

Respiratory Syncytial Virus (RSV)

- 90679 Respiratory syncytial virus vaccine, preF, recombinant, subunit, adjuvanted, for intramuscular use
- 90380 Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use
- 90381 Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use
- ⚡90683 Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use

(For seasonal respiratory syncytial virus [RSV] monoclonal antibodies immunization codes, see 90380, 90381. For administration of seasonal RSV monoclonal antibodies immunizations, use 96372)

Auditory

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

▶(Use 92623 in conjunction with 92622)

(Do not report 92622, 92623 in conjunction with 92626, 92627)

(For diagnostic analysis of cochlear implant, with programming or subsequent reprogramming, see 92601, 92602, 92603, 92604)

(For evaluation of auditory function for surgically implanted device[s] candidacy or postoperative status of a surgically implanted device[s], use 92626)

(For aural rehabilitation services following auditory osseointegrated implant, see 92630, 92633)

Coronary Therapeutic Services and Procedures

- #+92972 Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)

(Use 92972 in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975)

Phrenic Nerve Stimulation (PNS) System

- #93150 Therapy *activation* of implanted phrenic nerve stimulator system, including all interrogation and programming

  (Do not report 93150 in conjunction with 33276, 33277, 33278, 33279, 33280, 33281, 93151, 93152, 93153)

- #93151 *Interrogation and programming* (minimum one parameter) of implanted phrenic nerve stimulator system

  (Do not report 93151 in conjunction with 93150, 93152, 93153)

  (For interrogation without programming of implanted phrenic nerve stimulator system, use 93153)

- #93152 Interrogation and programming of implanted phrenic nerve stimulator system *during polysomnography*

  (Do not report 93152 in conjunction with 33276, 93150, 93151, 93153)

  (For polysomnography, see 95808, 95810, 95811, 95782, 95783)

- #93153 Interrogation *without* programming of implanted phrenic nerve stimulator system

  (Do not report 93153 in conjunction with 33276, 93150, 93151, 93152)

Phrenic Nerve Stimulation (PNS) System

Code	Description	Guidance	Guidance
93150	Therapy *activation* of implanted phrenic nerve stimulator system, including all interrogation and programming	Performed once after 30 days from implantation to allow for lead stabilization	Do not report with 33276, 33277, 33278, 33279, 33280, 33281, 93151, 93152, 93153
93151	*Interrogation and programming* (minimum one parameter) of implanted phrenic nerve stimulator system	Do not report with 93150, 93152, 93153	May be performed to evaluate device function and to optimize performance incrementally
93152	Interrogation and programming of implanted phrenic nerve stimulator system *during polysomnography*	Report once during polysomnogram regardless of how many programming changes are made over course of polysomnogram Do not report with 33276, 93150, 93151, 93153	
93153	Interrogation *without* programming of implanted phrenic nerve stimulator system	Do not report with 33276, 93150, 93151, 93152	

Venography for Congenital Heart Defects

#+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*

#+ 93585 Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; *azygos/hemiazygos venous system*

#+ 93586 Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; *coronary sinus*

#+ 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)

#+ 93588 Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; *venovenous collaterals originating below the heart* (eg, from the inferior vena cava)

Use with 93593, 93594, 93596, 93597

List separately in addition to code for primary procedure

Catheter placement in a normal SVC and a normal IVC is considered as part of a standard congenital cardiac catheterization.

Report once per session

Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)

- +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)
- +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)

Modalities – Constant Attendance

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

Do not report in conjunction with 0552T

For dynamic thermokinetic energies therapy, infrared, use 97026

Requires direct (one-to-one) patient contact.

Caregiver Training

- 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*
- +97551 *each additional 15 minutes* (List separately in addition to code for primary service)
- 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*

**These codes do not represent therapeutic interventions requiring direct one-to-one patient contact.

CMS Caregiver Training

- Medicare will pay for these services when furnished by a physician/APP or therapist as part of the patient's individualized treatment plan or therapy plan of care.
- Will recognize and pay
  - 96202, 96203 group training for caregivers in behavior management who are caring for different patients.
  - 97550, 97551 individual training for caregivers of an individual patient to facilitate functional performance at home and community relating to activities of daily living (ADL).
    - Time based
  - 97552 group training of multiple sets of caregivers care for different patients.
    - Not time based

Category III Codes

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- #0861T Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter).
- #0862T Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only.
- #0863T transmitter component only

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- #0790T Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed

Digital Pathology Digitization Procedures

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All are add-on codes – List separately in addition to code for primary procedure

- #+0827T Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; smears with interpretation
- #+0828T simple filter method with interpretation
- #+0829T Digitization of glass microscope slides for cytopathology, concentration technique, smears, and interpretation (eg, Saccomanno technique)
- #+0830T Digitization of glass microscope slides for cytopathology, selective cellular-enhancement technique with interpretation (eg, liquid-based slide preparation method), except cervical or vaginal

Digital Pathology Digitization Procedures

- #+0831T Digitization of glass microscope slides for cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
- #+0832T Digitization of glass microscope slides for cytopathology, smears, any other source; screening and interpretation
- #+0833T preparation, screening and interpretation
- #+0834T extended study involving over 5 slides and/or multiple stains

Digital Pathology Digitization Procedures

- #+0835T Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site
- #+0836T immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site
- #+0837T interpretation and report
- #+0838T Digitization of glass microscope slides for consultation and report on referred slides prepared elsewhere

Digital Pathology Digitization Procedures

- #+0839T Digitization of glass microscope slides for consultation and report on referred material requiring preparation of slides
- #+0840T Digitization of glass microscope slides for consultation, comprehensive, with review of records and specimens, with report on referred material
- #+0841T Digitization of glass microscope slides for pathology consultation during surgery; first tissue block, with frozen section(s), single specimen
- #+0842T each additional tissue block with frozen section(s)
- #+0843T cytologic examination (eg, touch preparation, squash preparation), initial site
- #+0844T cytologic examination (eg, touch preparation, squash preparation), each additional site

Digital Pathology Digitization Procedures

- #+0845T Digitization of glass microscope slides for immunofluorescence, per specimen; initial single antibody stain procedure
- #+0846T each additional single antibody stain procedure
- #+0847T Digitization of glass microscope slides for examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)
- #+0848T Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; initial single probe stain procedure
- #+0849T each additional single probe stain procedure
- #+0850T each multiplex probe stain procedure

Digital Pathology Digitization Procedures

- #+0851T Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; initial single probe stain procedure
- #+ 0852T each additional single probe stain procedure
- #+ 0853T each multiplex probe stain procedure
- #+0854T Digitization of glass microscope slides for blood smear, peripheral, interpretation by physician with written report
- #+0855T Digitization of glass microscope slides for bone marrow, smear interpretation
- #+0856TDigitization of glass microscope slides for electron microscopy, diagnostic

Office-Based Measurement of Mechanomyography and Inertial Measurement Units

- 0784T Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed
- 0785T Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator
- 0786T Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed
- 0787T Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator
- 0788T Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters

Office-Based Measurement of Mechanomyography and Inertial Measurement Units

- 0789T Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters
- +0791T Motor-cognitive, semi-immersive virtual reality–facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)
- 0792T Application of silver diamine fluoride 38%, by a physician or other qualified health care professional
- 0793T Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance

Pharmaco-oncologic Algorithmic Treatment Ranking

- 0794T Patient-specific, assistive, rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately

Dual-Chamber Leadless Pacemaker

- 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)

Dual-Chamber Leadless Pacemaker

- 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)

Dual-Chamber Leadless Pacemaker

- 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 right 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

Caval Valve Implantation [CAVI]

- 0805T Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach
- 0806T open femoral vein approach

Category III

- 0807T Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report
- 0808T in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report

Category III

- 0810T Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies

- 0811T Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment
- 0812T device supply with automated report generation, up to 10 days

- 0813T Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon

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

Category III

- 0815T Ultrasound-based radiofrequency echographic multispectrometry (REMS), bone-density study and fracture risk assessment, 1 or more sites, hips, pelvis, or spine
- 0816T Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous
- 0817T subfascial
- 0818T Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous
- 0819T subfascial

Continuous In-Person Monitoring During Psychedelic Medication Therapy

- +0820TContinuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; first physician or other qualified health care professional, each hour
- +0821Tsecond physician or other qualified health care professional, concurrent with first physician or other qualified health care professional, each hour (List separately in addition to code for primary procedure)
- +0822Tclinical staff under the direction of a physician or other qualified health care professional, concurrent with first physician or other qualified health care professional, each hour (List separately in addition to code for primary procedure)

Right Atrial Leadless Pacemaker

- 0823T Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed
- 0824T Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed
- 0825T Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed
- 0826T Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber

Category III

- 0857T Opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis and report (List separately in addition to code for primary procedure)
- 0858T Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report
- 0864T Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy
- 0865T Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session
- 0866T Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)

Telehealth After the PHE

Extended until 12/31/2024

- Telehealth can be provided in any site in the US where beneficiary is located, including the patient's home.
- Patient may be seen in their home, in any geographic location.
  - For patient in their home, use POS 10; services are paid at higher, non-facility rate.
  - Services submitted with POS 02 will be paid at lower facility rate.
- Physicians/APPs can use practice address (not home address) on telehealth claims when they are in their own home performing telehealth.
- Audio only visits (99441-99443) will be paid at 99212-99214 rate.
- RHC/FQHC payments for telehealth continue.

Telehealth After the PHE

- Delayed - Implementation of requirement for in-person visit with physician/APP within 6 months prior to initiating mental telehealth services.
  - Applies to RHC and FQHC
  - Until the end of 2024, all behavioral health services can be performed for Medicare patient via telehealth.
- Frequency limitations were lifted and continued coverage and payment will extend to 12/31/2024 on:
  - Subsequent hospital visits
  - Nursing facility visits
  - Critical care consults
- Direct supervision will continue to be allowed via two-way AV equipment.
  - Direct supervision means the supervising provider is in the suite where service is rendered and readily available.

Telehealth After the PHE

- Teaching physicians can use audio/video real-time communications when resident performs telehealth services in all residency training locations through end of 2024.
  - Virtual presence will meet teaching physician supervision requirements.
- Eligible telehealth providers will continue to include
  - Occupational therapists
  - Qualified physical therapists
  - Qualified speech language pathologists
  - Qualified audiologists
- Marriage and family therapists (MFT) and mental health counselors (MHC) will also be covered via telehealth 1/1/2024.

Telehealth After the PHE

CMS is adopting G2211

- G2211 Visit complexity inherent to E/M associated with medical care services that service as the continuing focal point for all needed health are services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition).
- Add-on code to 99202-99215
- May be used by primary care and other specialists who treat a single, serious condition or a complex condition with a consistency and continuity over a long period of time.
- May not be reported when modifier 25 is used on the E/M service on the day of a minor procedure.
- The provider/patient relationship should be continuous, consistent over time, longitudinal care.

Telehealth After the PHE

Split/Shared Services

- Report under the provider number of the practitioner who performed the substantive portion of the visit.
- Per CPT substantive portion is greater than 50% of the time OR MDM appropriately documented by billing provider.
- 2024 CPT has expanded rules on determining the substantive portion based on MDM.

Split/Shared Visits

The split or shared visits guidelines are applied to determine which professional may report the service. If the physician/QHP performs a substantive portion of the encounter, the physician/QHP may report the service.

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.

For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s)/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*. By doing so, a physician/QHP has performed two of the three elements used in the selection of the code level based on MDM.

If *the amount and/or complexity of data to be reviewed and analyzed* is used by the physician/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/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/QHP if these are used to determine the reported code level by the physician/QHP.

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Telehealth After the PHE

- CMS: For CY 2024 for purposes of Medicare billing for split/shared services, the definition of “substantive portion means more than half the total time spent by physician and APP performing the split/shared visit OR a substantive part of the MDM as defined by CPT”.
- “We expect that whoever performs the MDM and subsequently bills the visit would appropriately document the MDM in the medical record to support the billing of the visit”.

Questions?

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