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CPT Ortho Changes 2022

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CPT Summary 2022

- 10,819 codes
  - 405 Changes
    - New-249
    - Deleted-63
    - Revised-93

Changes by Specialty

- E/M-15
- Pathology and Laboratory-150
- Digital Medicine-10
- Radiology-20
- Orthopaedic Surgery-6
- Cardiology-35

E/M

- 99211
- ★ ▲ **99211 Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. ~~Usually, the presenting problem(s) are minimal~~.

New Place of Service Telehealth-10

- The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.
- (This code is effective January 1, 2022, and available to Medicare April 1, 2022.)
- UHC commercial accepting this place of service and 02 January 1, 2022

Final Rule Share (or split) E/M Visits

- In the facility setting the level of service will be determined based on time
- 2022: The practitioner that who performs the substantive portion of the visit will be the billing provider that can be history, exam, or MDM, or more than half of the total time spent.
- 2023:The practitioner that who provides 50% or more of the visit will be the billing provider
- A modifier will be required. The modifier is FS
- Both providers would have to be identified in the medical record
- The billing provider must sign and date the record
- 42 CFR 415.140

Evaluation and Management 2023

- Deletion of observation codes 99217-99226 and revision of codes 99221-99239 to include observation and revisions to the guideline
- Deletion of consultation codes 99241 and 99251 with revisions to the guidelines
- Revisions of the guidelines for ED, nursing facilities, and prolonged services

Restorative Care

- New explanations for fracture and dislocation treatment
- Organized by type of treatment
- A second manipulation would require a modifier 76
- Temporary stabilization(cast, splint) is not reported as treatment
- Use of modifier 54 when post-operative care will not be performed by provider that administers the initial treatment.

Spine Surgery Description Revisions

- 22600- single level changed to single interspace
- 22614- vertebral segment changed to interspace
- 22633- segment removed- just says interspace
- 63048- vertebral added to now say vertebral segment

Arthrodesis Decompression

- 62052 and 62053- laminectomy with decompression during posterior interbody arthrodesis-lumbar
- Add on codes to 22630,22632,22633,22634
- Did not change RVUs for arthrodesis
  - 63052- 4.25
  - 63053- 3.19

- 63194-63196 and 63198-63199-Deleted

Destruction of Intraosseous Basivertebral Nerve

- 64628-64629 two vertebral bodies, lumbar or sacral
- Radiofrequency for 15 minutes
- Back pain DDD
- 64628-first two vertebral bodies
- 64629- each additional vertebral body

Epidurography

- DELETED 72275

Trabecular Bone Score

- Spongy and porous part of a bone
- Performed as an addition to Dexascan
- 77089- TBS using DXA or other imaging data with calculation, interpretation and report on fracture risk
- 77090- technical preparation and transmission
- 77091- technical calculation only
- 77092- interpretation and report only

Extracorporeal Shock Wave Therapy

- No level of energy is in the description of codes- high energy has been removed
- 0101T-0102T
- 0512T-0513T

Anterior Vertebral Body Tethering

- 0656T-0657T
- Scoliosis
- Not reported in addition to arthrodesis/kyphectomy or instrumentation
- Illustrations CPT Professional 2022 pages 164-165

Subchondroplasty

- 0707T- Injection(s), bone-substitute material (eg, calcium phosphate) into subchondral bone defect (ie, bone marrow lesion, bone bruise, stress injury, microtrabecular fracture), including imaging guidance and arthroscopic assistance for joint visualization

PRP-Medicare

- Effective April 1, 2021:
- G0465 Autologous platelet rich plasma (prp) for diabetic chronic wounds/ulcers, using an FDA-cleared device (includes administration, dressings, phlebotomy, centrifugation, and all other preparatory procedures, per treatment)
- G0460 Autologous platelet rich plasma for non-diabetic chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment
- Remember: The HCPCS Level II code set only identifies categories of items and services. The existence or absence of a HCPCS Level II code does not mean an item or service is covered or non-covered under Medicare. Check your payer policies and the National Correct Coding Initiative file for coverage indictors.

2022 Annual Therapy Update

- https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate
  - Describes “always therapy” from “sometimes” therapy codes
    - Always therapy codes require GO or GP modifiers
      - Must be part of a plan of care
        - 97760 billed by other providers

2022 Threshold Exceptions

- $2,150 for PT and SLP combined
- $2,150 for OT
- Modifier KX is required
  - Report in addition to other modifiers
- Attestation of the medical necessity of services
- Medical records contain supporting documentation
- Report ICD-10 for specific underlying condition or body part affected

2022 Final Rule Therapy Assistants

- https://www.cms.gov/medicare/therapy-services/billing-examples-using-cqco-modifiers-services-furnished-whole-or-part-ptas-and-otas

2022 Therapy Services involving an Assistant

STEP 1

- List codes with total number of minutes done by each provider with at least 15 minutes and less than 30 minutes
- Modifier CQ/CO is applied
  - When the PTA/OTA furnished 8 minutes or more of a service and the PT/OT provides less than 8 minutes
  - Both the PTA/OTA and the PT/OT each furnish less than eight minutes for the final 15-minute unit of billing

CMS Example 1

- PTA - 10 minutes of 97110
- PT – 5 minutes of 97110

- Total = 15 minutes – qualifies to bill one 15-minute unit (8 minutes to 22 minutes).

- 97110-CQ- PTA provided more than 10% of the service- 66%

CMS Example 2

- PTA - 5 minutes of 97110
- PT – 6 minutes of 97110

- Total = 11 minutes – qualifies to bill one 15-minute unit (8 minute through 22 minutes).

- 97110-CQ- PTA provided more than 10% of the service- 45%

CMS Example 3

- PTA – 5 minutes 97110
- PT – 30 minutes 97110

- Total = 35 minutes – 2 units can be billed (23 minutes through 37 minutes).

- 97110x2- no modifier

De Minimus Percentage Method

- Determine if there are remaining minutes provided by the PTA/OTA and the PT/OT for the same service. If so, divide the remaining PTA/OTA time by the total time (PTA/OTA minutes + PT/OT minutes for the same service). Then multiply by 100 to get the percentage and round to the nearest integer. Where this number is greater than 10 percent (11 percent or more), the CQ/CO modifier applies.

De Minimis Simple Method

- For instances where there are remaining minutes for the same service provided by the PTA/OTA and the PT/OT, add these together, divide that total by 10, then round to the nearest integer to get the 10 percent de minimis standard for that service. Then, add 1 minute to get the PTA/OTA minute floor. The CQ/CO modifier applies when the PTA/OTA minutes meet or exceed this floor number.

CMS Example 4

- PTA-22 minutes of 97110
- PT – 23 minutes of 97110

- Total = 45 minutes – qualifies to bill 3 15-minute units (38 minutes through 52 minutes).

- Bill 97110 with CQ for PTA and 1 full unit and 97110x2 without the modifier 1 full unit provided by PT and 1 unit following the 8 minute rule for the final unit

Two 15-mimute Units Remain

- For these limited cases, one 15-minute unit to be billed with the CQ/CO modifier and one 15-minute unit to be billed without the CQ/CO modifier in billing scenarios where there are two 15-minute units left to bill when the PT/OT and the PTA/OTA each provide between 9 and 14 minutes of the same service when the total time is at least 23 minutes and no more than 28 minutes.

CMS Example 5

- PT – 12 minutes of 97110
- PTA-14 minutes of 97110
- PT – 20 minutes of 97140

- Total = 46 minutes – qualifies to bill three units (38 minutes through 52 minutes)

- Bill 1 unit of 97140 without CQ because PT provided the whole service. 1 unit of 97110 with a CQ and 1 unit of 97110 without the CQ modifier

Two Different 15 Minute Services

- Compare the remaining minutes furnished by the PT/OT for the one service with the remaining minutes furnished by the PTA/OTA for the different service. Bill for the service that took the most time. That is, assign the CQ/CO modifier to the service provided by the PTA/OTA when the time he/she spent is greater than the time spent by the PT/OT performing the different service. The CQ/CO modifier does not apply when the minutes spent delivering a service by the PT/OT are greater than the minutes spent by the PT/OTA delivering a different service.

CMS Example 6

- PTA – 19 minutes of 97110
- PT – 10 minutes of 97140

- Total = 29 minutes – two units can be billed (23 minutes through 37 minutes).

- Bill 1 unit of 97110 with CQ because PTA performed a full unit and bill 97140 without CQ because PT's time of 10 minutes is greater than PTA's remaining time of 4 minutes

Tie-Breaker

- When determining there is only one unit left to bill, the remaining minutes for each service – one provided by the PT/OT and the other provided by the PTA/OTA – are the same, either service may be billed, but not both. If the service provided by the PT/OT is billed, the CQ/CO modifier does not apply. However, if the service provided by the PTA/OTA is billed, the CQ/CO modifier does apply.

CMS Example 7

- OTA-11 minutes of 97535
- OT – 11 minutes of 97530

- Total = 22 minutes – qualifies to bill one (1) unit (8 minutes through 22 minutes)

- Bill 1 unit of 97535 with CO for OTA and 1 unit of 97530 without CO for OT.

2022 Untimed Therapy

- The de minimis policy is applicable when the PT and the PTA or the OT and the OTA each independently provide minutes of the same untimed service, including: supervised modalities, evaluations and re-evaluations, group therapy, and certain RTM codes. In these cases, either the simple or percentage method can be used to determine if the PTA/OTA furnished more than 10 percent of the service. If so, the CQ/CO modifier is appended to the claim for that unit of service.

CMS Example 8

- OTA – 20 minutes 97150 independent of the OT
  OT – 20 minutes 97150 independent of the OTA
- Total = 40 minutes of Group Therapy = 1 unit of 97150 is billed for each group member
- Bill 97150 with a CO modifier for OTA- 50%