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2022 Coding Updates and Changes

CPT ®, HCPCS, and ICD-10

January 2022

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Current Procedural Terminology (CPT)

New, Revised and Deleted CPT Codes

New CPT Codes

Care Management Services

Principal Care Management Services (CPT codes 99424-99427)

New CPT codes are now available to describe "Principal Care Management Services." These codes are like chronic care management services in that the work involves the establishment, implementation, revision, and monitoring of a care plan for a patient. However, principal care management focuses on a *single* condition (rather than two or more).

CPT code 99424 describes the first 30 minutes of a Principal Care Management service per calendar month provided by *a physician or qualified healthcare professional*. To capture each additional 30 minutes of service in addition to 99424, CPT code 99425 would be reported. CPT codes 99426 and 99427 also describe principal care management services, but for *clinical staff time directed by a physician or qualified healthcare professional*.

Effective January 1, 2022, Medicare will accept CPT codes 99424, 99425, 99426, and 99427; and discontinue HCPCS codes G2064 and G2065.

CPT Code	HCPCS Code
99424- Principal care management services, for a single high-risk disease, with the following required elements: ▪ one complex chronic condition expected to last at least 3 months, ▪ places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, ▪ the condition requires development, monitoring, or revision of disease-specific care plan, ▪ the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ▪ ongoing communication and care coordination between relevant practitioners furnishing care. ▪ first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.	G2064- Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: ▪ One complex chronic condition lasting at least 3 months, which is the focus of the care plan, ▪ The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, ▪ The condition requires development or revision of disease-specific care plan, ▪ The condition requires frequent adjustments in the medication regimen, and/or ▪ The management of the condition is unusually complex due to comorbidities
99425-each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List	

separately in addition to code for primary procedure)	
99426- Principal care management services, for a single high-risk condition disease… first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.	G2065- Comprehensive care management for a single high-risk disease service, e.g., Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99427- each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	

Chronic Care Management (Physician or QHP)

A new CPT code was created to describe each additional 30 minutes of a chronic care management service performed by a physician or qualified healthcare professional. CPT code 99437 may be reported *in addition* to CPT code 99491, which accounts for the first 30 minutes of a chronic care management service. Both 99491 and 99437 may only be reported when the service reaches 30 minutes.

CPT Code Description

99437-each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Remote Therapeutic Monitoring and Management Services

With the increase in telemedicine during the pandemic, new CPT codes were created to describe "Remote Therapeutic Monitoring Services" and "Remote Therapeutic Monitoring Treatment Management Services". These services encompass the monitoring and management of non-physiologic data.

Remote Therapeutic Monitoring

CPT codes 98975-98977 are reported once for each 30-day episode of care and may not be reported for a service less than 16 days. The codes account for both objective device-generated data and inputs provided by the patient.

CPT code 98975 describes the initial set up and patient education process for remote therapeutic monitoring (which includes respiratory system status, musculoskeletal system status, therapy adherence, and therapy response). CPT codes 98976 and 98977 both refer to the supply of devices with scheduled recordings and/or programmed alerts transmissions for a period of 30 days. However, 98976 applies to the monitoring of the *respiratory* system while 98977 applies to the *musculoskeletal* system.

These codes should not be used to describe services such as physiologic monitoring (a blood, urine, or other bodily substance test that measures function), patient management, or self-measured blood pressure management.

CPT Code Descriptions

98975- Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment

98976- device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days

98977- device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days

Remote Therapeutic Monitoring Treatment Management Services

Corresponding to the "Remote Therapeutic Monitoring" CPT codes are "Remote Therapeutic Monitoring Treatment Management Services." "Remote Therapeutic Monitoring Treatment Management Services" are ordered by a physician or qualified healthcare professional, who use the data from remote therapeutic monitoring to manage a patient who is under a specific treatment plan. These services may also be reported in addition to care management services such as chronic care management services, transitional care management services, and principal care management services (new in 2022). However, the time spent on each should not be combined- rather, they are calculated separately.

An interactive communication between the physician or qualified healthcare professional and the patient and/or caregiver is required and may contribute to the total time of the service.

CPT code 98980 describes the first 20 minutes of the service in a calendar month, and 98981 accounts for each additional 20 minutes (in addition to 98980). Both codes may not be reported for a service less than 20 minutes.

CPT Code Descriptions

98980- Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes

98981- each additional 20 minutes (List separately in addition to code for primary procedure)

Radiology

Bone and Joint Studies

Four new codes (CPT codes 77089-77092) are available in 2022 to describe the work associated with a "Trabecular Bone Score (TBS)." Two codes- 77090 and 77092 are technical only and do not include physician work.

CPT Code Descriptions

77089-Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual X-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture-risk

77090- Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere

77091- Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only

77092- Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture-risk only by other qualified health care professional

CPT codes 77090, 77091, and 77092 may NOT be reported with 77089, and vice versa.

Pathology and Laboratory

Pathology Clinical Consultations

In 2022, CPT codes have been established for Pathology Clinical Consultation services that are provided at the request of a physician or qualified healthcare provider from the same institution or facility. The request can be a clinical assessment, an evaluation of pathology or lab findings, or other information that needs an additional assessment. If findings are reporting without an interpretation, it is not considered a consult.

Like office and outpatient evaluation and management services, CPT codes 80503-80505 are selected based on either time *or* medical decision making. In addition, a 30-minute prolonged services code was created to add onto CPT code 80505 (if applicable). Unlike office an outpatient E/M services, however, there is no exam or evaluation of the patient- those services should be reported with office, outpatient, or inpatient consultation services.

CPT Code Descriptions

80503- Pathology clinical consultation; for a clinical problem, with limited review of patient's history and medical records and straightforward medical decision making. When using time for code selection, 5-20 minutes of total time is spent on the date of the consultation.

80504- For a moderately complex clinical problem, with review of patient’s history and medical records and moderate level of medical decision making. When using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.

80505- For a highly complex clinical problem, with comprehensive review of patient’s history and medical records and high level of medical decision making. When using time for code selection, 41-60 minutes of total time is spent on the date of the consultation.

80506- Prolonged service, each additional 30 minutes (List separately in addition to code for primary procedure)

Multianalyte Assays with Algorithmic Analyses

A new CPT code of interest to oncology was added to the section regarding "Multianalyte Assays with Algorithmic Analyses":

81523- Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as index related to risk to distant metastasis

Coronavirus- Vaccines and Testing

In 2021, AMA created new codes to describe COVID-19 vaccine and testing services. These codes, which have been published on the AMA website throughout 2021, can also now be found in the 2022 AMA CPT® Professional Edition. The codes for vaccines are specifically listed in Appendix Q "Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) Vaccines."

ASCO's Coronavirus Resource Center provides a resource dedicated to COVID-19 related coding and reported information which includes CPT codes, HCPCS codes, and ICD-10 codes.

Modifiers

Synchronous Telemedicine Service

Modifier -93 was created to describe a "Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System." CPT defines synchronous telemedicine as a "real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional." A synchronous service conducted via a telephone or audio-only communications system must meet the requirements of the service as if it was rendered face-to-face.

The modifier is reportable as of January 1, 2022, though it won't be published in the AMA CPT Manual until 2023.

Appendix R: Digital Medicine – Services Taxonomy

The AMA CPT manual for 2022 now includes an appendix (Appendix P) which lists digital medicine services currently in the CPT code set. The corresponding table classifies services into four categories:

- Clinician-to-Patient Services (eg, visit)
- Clinician-to-Clinician Services (eg, consultation)
- Patient Monitoring and/or Therapeutic Services
- Digital Diagnostic Services

It further breaks down the services by detailing the encounter/activity and the related CPT code to assist with the reporting of the most appropriate code for the service provided.

Revised CPT Codes

Office and Outpatient Evaluation and Management Services

The phrase "usually the presenting problems are minimal" was removed from the code description of CPT code 99211.

Healthcare Common Procedure Coding System (HCPCS)

Medicare Physician Fee Schedule 2022 Final Rule Updates

Brief Communication Technology Based Services

In 2021, the Centers for Medicare and Medicaid Services (CMS) established HCPCS G2252 for payment on an *interim* basis. For CY 2022, CMS finalized both separate coding and payment for the service. The decision to permanently cover the service was influenced by stakeholder comments that additional time may be needed to assess the necessity of an in-person service.

HCPCS Code Description

G2252- Brief communication technology-based service, e.g., virtual check-in service, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion).

Principal Care Management Services

For CY 2022, CMS is replacing Principal Care Management services HCPCS codes G2064 and G2065 in the PFS with new Principal Care Management CPT codes 99424 and 99426. This will also include Principal Care Management Services 99425 and 99427, which describe each additional 30 minutes of service (there is currently no HCPCS code to describe the additional 30 minutes of work)

Other Updates: Medicare Physician Fee Schedule 2022 Final Rule

Split/Shared Visits for Prolonged Evaluation and Management Services

As stated in the current Medicare Claims Processing Manual, Prolonged Evaluation and Management Services may not be reported as a split or shared visit. However, it was determined by CMS since a Prolonged E/M service is an extension of the primary E/M visit, it may also be reported as split/shared.

Beginning in **2023**, the physician or practitioner *who spent more than half the total time* will bill for the E/M visit the service is provided as a split or shared visit. To establish who will report the services, the physician and NPP will simply add their time together. Whomever provided more than half the service (including the prolonged service time) may report both the primary service and the prolonged service add on code.

This policy will also apply in the 2022 transition year, however, for shared office/outpatient visits when practitioners use a key component as the substantive portion, a prolonged service may be reported by the practitioner who reports the primary service, when the combined time of both practitioners meets the threshold for reporting a 15-minute prolonged service on the date of an office/outpatient visit (HCPCS code G2212).

Split/Shared Visits for New Patient Evaluation and Management Services

To align their policies with the increased number of team-based approaches to care, CMS will allow physicians or NPPs in the same practice to bill for split or shared visits for both new and established patients in addition to initial and subsequent visits in the facility setting (“Incident to” services still apply to the office/outpatient setting).

Either the physician or non-physician practitioner may bill Medicare directly for the visit. The provider who reports the “substantive portion” of the visit, which CMS defined as more than half the time, bills Medicare. In the event of a split/shared visit the name of both individuals are included in the medical record, and the billing individual must sign and date it.

ICD-10 CM Updates

The Centers for Medicare and Medicaid Services published ICD-10 CM updates effective **October 1st, 2021** through **September 30th, 2022.** Several new codes and changes were made in Chapter 2 (Neoplasms) and Chapter 3 (Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism) as well as in Chapter 21 (Factors influencing health status and contact with health services). A full list of changes can be found in the "Addendum" files on the ICD-10 CM updates page. Questions about ICD-10 CM codes may be sent to ASCO at billingandcoding@asco.org.

New ICD-10 CM Codes

Chapter 2- Neoplasms (C00-D49)

C56.3 Malignant neoplasm of bilateral ovaries

C79.63 Secondary malignant neoplasm of bilateral ovaries

C84.7A Anaplastic large cell lymphoma, ALK-negative, breast

Breast implant associated anaplastic large cell lymphoma (BIA-ALCL)
Use Additional code to identify:
breast implant status (Z98.82)
personal history of breast implant removal (Z98.86)

Chapter 3- Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)

D55.21 Anemia due to pyruvate kinase deficiency
PK deficiency anemia
Pyruvate kinase deficiency anemia

D55.29 Anemia due to other disorders of glycolytic enzymes
Hexokinase deficiency anemia
Triose-phosphate isomerase deficiency anemia

D89.44 Hereditary alpha tryptasemia
Use additional code, if applicable, for:
allergy status, other than to drugs and biological substances (Z91.0-)
personal history of anaphylaxis (Z87.892)

ICD-10 CM TERMS AND DEFINITIONS

Excludes 1: Indicates conditions that may *not* be reported together. The "Excludes 1" code should note be used at the same time as the code above the note.

Excludes 2: Indicates that although the excluded condition is *not* part of the condition it is excluded from. However, the patient may have both conditions at the same time. The Excludes 2 code may be used as the same time as the code above it.

NOS: Not Otherwise Specified. This abbreviation is the equivalent of unspecified.

Use Additional Code: An additional code should be reported to provide a complete picture of the diagnosis.

Code Also: More than one code may be required to fully describe the condition.

Chapter 21- Factors influencing health status and contact with health services (Z00-Z99)

Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)

Z55.5 Less than a high school diploma
No general equivalence degree (GED)

Z58 Problems related to physical environment
Excludes:2: occupational exposure (Z57.-)

Z58.6 Inadequate drinking-water supply
Lack of safe drinking water
Excludes2: deprivation of water (T73.1)

Z59.00 Homelessness unspecified

Z59.01 Sheltered homelessness
Doubled up
Living in a shelter such as: motel, scattered site housing, temporary or transitional living situation

Z59.02 Unsheltered homelessness
Residing in place not meant for human habitation such as: abandoned buildings, cars, parks, sidewalk
Residing on the street

Z59.41 Food insecurity

Z59.48 Other specified lack of adequate food

Z59.81 Housing instability, housed
Foreclosure on home loan
Past due on rent or mortgage
Unwanted multiple moves in the last 12 months

Z59.811 Housing instability, housed, with risk of homelessness
Imminent risk of homelessness

Z59.812 Housing instability, housed, homelessness in past 12 months

Z59.819 Housing instability, housed unspecified

Z59.89 Other problems related to housing and economic circumstances
Foreclosure on loan
Isolated dwelling
Problems with creditors

Persons with potential health hazards related to family and personal history and certain conditions influencing health status (Z77-Z99)

Z92.85 Personal history of cellular therapy

Z92.850 Personal history of Chimeric Antigen Receptor T-cell therapy

Z92.858 Personal history of other cellular therapy

Z92.859 Personal history of cellular therapy, unspecified

Z92.86 Personal history of gene therapy

Revisions and Updates

Current Language	Revised Language
C25 Malignant neoplasm of pancreas Code also: exocrine pancreatic insufficiency (K86.81)	C25 Malignant neoplasm of pancreas Code also: **if applicable** exocrine pancreatic insufficiency (K86.81)
D47.3 Essential (hemorrhagic) thrombocythemia	D47.3 Essential (hemorrhagic) thrombocythemia **Primary thrombocytosis** **Excludes2: reactive thrombocytosis (D75.838)** **secondary thrombocytosis (D75.838)** **thrombocythemia NOS (D75.839)** **thrombocytosis NOS (D75.839)**
D55.2 Anemia due to disorders of glycolytic enzymes Hemolytic nonspherocytic (hereditary) anemia, type II Hexokinase deficiency anemia Pyruvate kinase [PK] deficiency anemia Triose-phosphate isomerase deficiency anemia	D55.2 Anemia due to disorders of glycolytic enzymes ~~**Hemolytic nonspherocytic (hereditary) anemia, type II**~~ ~~**Hexokinase deficiency anemia**~~ ~~**Pyruvate kinase [PK] deficiency anemia**~~ ~~**Triose-phosphate isomerase deficiency anemia**~~
D57.43- Sickle-cell thalassemia beta zero with crisis, unspecified Sickle-cell thalassemia beta zero with vasoocclusive pain	D57.43- Sickle-cell thalassemia beta zero with crisis, unspecified Sickle-cell thalassemia beta zero with vasoocclusive pain **NOS**
D57.459 Sickle-cell thalassemia beta plus with crisis, unspec Sickle-cell thalassemia beta plus with vasoocclusive pain	D57.459 Sickle-cell thalassemia beta plus with crisis, unspecified Sickle-cell thalassemia beta plus with vasoocclusive pain **NOS**
D64.81 Anemia due to antineoplastic chemotherapy Excludes1: aplastic anemia due to antineoplastic chemotherapy (D61.1)	D64.81 Anemia due to antineoplastic chemotherapy ~~**Excludes1: aplastic anemia due to antineoplastic chemotherapy (D61.1)**~~ **Excludes2: aplastic anemia due to antineoplastic chemotherapy (D61.1)**
D68.5 Primary thrombophilia Excludes 1: thrombotic thrombocytopenic purpura (M31.1)	D68.5 Primary thrombophilia Excludes 1: thrombotic thrombocytopenic purpura (M31.1**9**)
D72.1 Eosinophilia Excludes2: Löffler's syndrome (J82)	D72.1 Eosinophilia Excludes 2: Löffler's syndrome (J82.89)

pulmonary eosinophilia (J82)	pulmonary eosinophilia **(J82.-)**
Z59.4 Lack of adequate food and safe drinking water Excludes1: effects of hunger (T73.0) inappropriate diet or eating habits Z72.4) malnutrition (E40-E46)	Z59.4 Lack of adequate food ~~**and safe drinking water**~~ ~~**Excludes1: effects of hunger (T73.0)**~~ ~~**inappropriate diet or eating habits Z72.4)**~~ ~~**malnutrition (E40-E46)**~~ **Excludes2: deprivation of food (T73.0)** **effects of hunger (T73.0)** **inappropriate diet or eating habits (Z72.4)** **malnutrition (E40)**
Z59.8 Other problems related to housing and economic circumstances Foreclosure on loan Isolated dwelling Problems with creditors	Z59.8 Other problems related to housing and economic circumstances ~~**Foreclosure on loan**~~ ~~**Isolated dwelling**~~ ~~**Problems with creditors**~~

Resources

Centers for Medicare and Medicaid Services 2022 ICD-10-CM