Code Changes for 2023

Evaluation and Management

The E/M section is overhauled to bring all the E/M categories in line with the guidelines that were released in CPT® 2021. There are a lot of code changes to unpack in this section, and a thorough review is necessary. These changes render the Centers for Medicare & Medicaid Services' (CMS') 1995 or 1997 Documentation Guidelines for E/M Services outdated. In the 2023 Medicare Physician Fee Schedule (PFS) proposed rule, CMS said it planned to accept the CPT® 2023 E/M guidelines with some modifications. (The final rule had not been published at the time of this writing, so stay tuned for those modifications.) This is a monumental change to have one set of guidelines for E/M services and should alleviate some of the administrative burdens on providers, coders, and auditors.

The medical decision making (MDM) table is revised to be used with all other E/M categories where MDM is a coding option. Definitions added throughout the guidelines include examples and clarification for when to use MDM for code selection in the other categories. There is also a difference for total time in the descriptors: Instead of a time range (for example, 99202 *Office or other outpatient visit for the evaluation and management of a new patient … 15-29 minutes of total time*), the other category codes include the amount of time that must be met. For example, the code descriptor for 99221 includes "40 minutes must be met or exceeded."

The Hospital Observation Services and Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Oversight Services subcategory is deleted. For 2023, observation care services are reported with hospital inpatient services codes, which are revised to include hospital inpatient and observation care services. Also in CPT® 2023, Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services codes were deleted and merged with Home Services codes 99341-99350 (except for deleted code 99343).

Many coders were expecting consultation services to be deleted altogether, but that is not the case. Only level one consultation codes 99241 and 99251 are deleted. Although Medicare does not reimburse consultation codes, other payers do; and the medical specialties feel that the services performed in a consultation are distinct from other E/M services and that the consultation code descriptors better describe the work performed.

Emergency department visits (99281-99285) are reported based on MDM only — the total time concept doesn't apply in the ED setting. Another coding concept introduced is that 99281 may not require the presence of a physician or other qualified healthcare professional. In this section, 99281 is compared to 99211 in the office and outpatient setting.

The annual nursing facility assessment code 99318 was deleted; you will instead use the subsequent nursing facility care codes (99307-99310) or Medicare G codes. The nursing facility care codes are also revised and new guidelines exist.

Lastly, in this section, there is a new prolonged services add-on code (99418) for use only after the highest level of E/M is reached, based on total time in the inpatient and observation care or

nursing facility. This add-on code is reported in 15-minute increments. Code 99417 is revised and may be reported with home and residence services and outpatient consultation codes.

Surgery: Integumentary System

Removal of sutures under anesthesia code 15850 was deleted, and 15851 is revised to “sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation.” “Other surgeon” was removed from the code descriptor. Two new add-on codes allow you to capture the practice expense when sutures or staples are removed in the office at the time of an E/M service: Code 15853 for the removal of sutures or staples not requiring anesthesia and 15854 for the removal of sutures and staples not requiring anesthesia.

Surgery: Musculoskeletal System

The code for total disc arthroplasty (22857) is revised to make “single interspace, lumbar” a suffix. Use new add-on code 22860 when total disc arthroplasty is performed on the second interspace of the lumbar spine.

Surgery: Respiratory System

A new code for the repair of a nasal valve collapse, 30469, is added to report the use of low-energy, temperature-controlled subcutaneous/submucosal remodeling.

Surgery: Cardiovascular System

CPT® 2023 includes five new codes for percutaneous pulmonary artery revascularization by stent placement. Introductory guidelines and parentheticals are also added.

- Code 33900 is for an initial procedure performed unilaterally in normal native connections.
- Code 33901 is for an initial procedure performed bilaterally in normal native connections.
- Code 33902 is for an initial procedure performed unilaterally in abnormal connections.
- Code 33903 is for an initial procedure performed bilaterally in abnormal connections.
- Code +33904 reports each additional vessel or separate lesion in normal or abnormal connections. This add-on code can be reported with 33900, 33901, 33902, or 33903.

Two new codes are added for percutaneous arteriovenous fistula creation: Code 36836 describes stent placement across major side branches (existing code 33895 describes single access of both the peripheral artery and peripheral vein including fistula maturation procedures), and code 36837 describes separate access sites of the peripheral artery and peripheral vein including fistula maturation procedures. Both procedures include vascular access, imaging guidance, and radiologic supervision and interpretation.

Surgery: Digestive System

A new code, 43290, describes esophagogastroduodenoscopy (EGD) with the deployment of an intragastric bariatric balloon. For the removal of the intragastric bariatric balloon(s) by EGD, use new code 43291.

There are extensive changes to the hernia repair codes for abdominal hernias which include epigastric, incisional, ventral, umbilical, and spigelian hernias. Eighteen codes were deleted and replaced with 15 new codes. Introductory guidelines and parentheticals are also added. The new code family includes any approach because these procedures can be performed using a combination of approaches in a hybrid model. Select these codes based on whether the procedure is initial or recurrent, reducible, incarcerated, or strangulated, and the total defect size:

- Codes 49591-49596 are for the initial procedure.
- Codes 49614-49618 are for recurrent abdominal hernia repairs.
- Codes 49621 and 49622 describe the repair of a parastomal hernia.

All the new procedures include mesh implantation. If during the procedure noninfected mesh is removed, report add-on code 49623 in addition to the code for the hernia repair. This new add-on code can only be reported with codes 49591-49622.

Surgery: Urinary System

Codes for percutaneous nephrolithotomy or pyelolithotomy (50080 and 50081) are revised to clarify which services are included when performing the procedure, so they can be properly valued. Code 50080 is reported for a simple procedure that involves stones up to 2.0 cm. Stones greater than 2.0 cm, branching stones, stones in multiple locations, ureter stones, and anatomical complications are considered complex and reported with 50081.

Surgery: Male Genital System

Laparoscopic simple subtotal prostatectomy is described by new code 55867. This procedure includes robotic assistance when performed.

Surgery: Nervous System

Codes in the nerve injection family (64415-64417 and 64445-64448) are revised to include imaging guidance when performed.

Surgery: Eye and Ocular Adnexa

Transluminal dilation of aqueous outflow canal codes 66174 and 66175 are revised to include canaloplasty, as an example.

Surgery: Auditory System

The osseointegrated implant procedure codes 69717, 69719, 69726, and 69727 are revised and three new codes are added:

- Code 69728 describes the removal of the osseointegrated implant with magnetic transcutaneous attachment to an external speech processor outside of the mastoid that results in the removal of greater than or equal to 100 sq mm surface area of bone.
- Code 69729 describes the implantation of the osseointegrated implant with magnetic transcutaneous attachment to an external speech processor outside of the mastoid that results in the removal of greater than or equal to 100 sq mm surface area of bone.
- Code 69730 describes the replacement including the removal of the implant with magnetic transcutaneous attachment to an external speech processor outside of the mastoid that results in the removal of greater than or equal to 100 sq mm surface area of bone.

Radiology

The descriptor for limited ultrasound code 76882 is revised to include "focal evaluation of," and the descriptors for tomographic SPECT codes 78803, 78830, 78831, and 78832 are revised to include "or acquisition." Also in this section, new code 76883 describes an ultrasound of the nerves and accompanying structures throughout the entire anatomic course in one extremity.

Pathology and Laboratory

New code 81418 describes a drug metabolism genomic sequence analysis panel. Inherited bone marrow failure syndromes testing is described with new code 81441.

Codes 81445, 81450, and 81455 are revised to specify that the procedure includes DNA analysis or combined DNA and RNA analysis. When the targeted genomic sequence analysis panel for a solid organ neoplasm involves only RNA analysis, use new code 81449; and when the targeted genomic sequence analysis panel for hematolymphoid neoplasms or disorder includes only RNA analysis, use new code 81451.

There are also many new proprietary laboratory analyses (PLA) codes. These codes describe PLAs provided by either a single laboratory or licensed/marketed to multiple providing laboratories. This subsection includes multianalyte assays with algorithmic analyses (MAAA) and genomic sequencing procedures (GSP).

Medicine

Codes for COVID-19 vaccines are released for early use based on the public health emergency. The vaccine administration codes include the type of vaccine and the number of doses. To properly report COVID-19 vaccines, there is an administration code and a supply code (if your provider did not receive the supply of the vaccine for free). Appendix Q is added for coding clarification on the proper use of the COVID-19 vaccine administration and supply codes.

Four new codes are added to the cardiac catheterization subcategory for angiography procedures.

- Code 93569 describes unilateral selective pulmonary arterial angiography.
- Code 93573 describes bilateral selective pulmonary arterial angiography.
- Code 93574 describes selective pulmonary venous angiography of each distinct pulmonary vein.

- Code 93575 describes a selective pulmonary angiography of major aortopulmonary collateral arteries arising off the aorta or its systemic branches.