CPT and HCPCS Changes 2024

December 2023

Integrated Revenue Integrity, Inc.
225 Cedar Hill Street, Suite 200, Marlborough, MA 01752
Tel (508) 630-2141 | Fax (508) 630-1662
www.integratedri.com | info@integratedri.com

Contents

Part I: Key Changes to CPT® for 2024 6

Guide to Symbols Used in this Manual 7
Release of CPT Codes 8

Evaluation and Management Services 10

Office or Other Outpatient Visits 10
Nursing Facility Care 13
Pelvic Examination 14
Split or Shared Visits 15
Multiple Evaluation & Management Services on the Same Date 17
Hospital Inpatient and Observation Care 19

Anesthesia 20
Integumentary System 20
Musculoskeletal System 21

Thoracic Vertebral Body Tethering 21
SI Joint Arthrodesis 23
Bunion Correction 24

Respiratory System 25

Posterior Nasal Nerve Ablation 25

Cardiovascular System 26

Phrenic Nerve Stimulation System 26

Hemic and Lymphatic Systems 29
Mediastinum and Diaphragm 29
Digestive System 29
Urinary System 30

Cystopic Drug Delivery 30

Male Genital System 31
Female Genital System 32

Transcervical Ablation of Uterine Fibroids 32

Maternity Care and Delivery 33
Endocrine System 33
Nervous System 34

Skull-Mounted Cranial Neurostimulator 34
Spinal and Peripheral Nerve Neurostimulator Services 35
Eye and Ocular Adnexa 37
Suprachoroidal Injection 37
Auditory System 38
Radiology 39
Pelvimetry 39
Fractional Flow Reserve with CT 40
Intraoperative Cardiac Ultrasound 42
Pathology and Laboratory 44
Molecular Pathology Editorial Language Revisions 44
Tumor Genomics Testing 46
Multianalyte Assays with Algorithmic Analysis (MAAAs) 50
Chemistry 52
Immunology 53
Microbiology 54
Proprietary Laboratory Analysis (PLA) Codes 55
Medicine 56
Immune Globulins, Serum, or Recombinant Products 56
Immunization Administration, Vaccines & Toxoids 58
Auditory Osseointegrated Device Services 61
Coronary Lithotripsy 62
Phrenic Nerve Stimulation System 63
Venography for Congenital Heart Defects 65
Hyperthermic Intraperitoneal Chemotherapy (HIPEC) 67
Laser Treatment for Skin Disease 69
Postoperative Low Level Laser Therapy 70
Caregiver Training Services 71
Category II Codes 73
Category III Codes 74
New Category III Codes Effective in 2023 75
Deleted Category III Codes with No Replacements 77
Noncontact Near-Infrared (NIR) Spectroscopy 78
Wireless Cardiac Stimulation System for Left Ventricular Pacing 79

Tibial Integrated Neurostimulators 81
Lumbar or Thoracolumbar Vertebral Body Tethering 83
Digital Pathology 84
Peripheral Nerve Transcutaneous Magnetic Stimulation 90
Spinal and Sacral Integrated Neurostimulators 91
Remote Multi-Day Complex Uroflowmetry 93
Adjustment of Gastric Balloon 94
Insertion of Calcium-Based Implant - Femur 95
Ultrasound-Based REMS Axial Bone Density Study 96
Psychedelic Drug Monitoring Services 97
Right Atrial Leadless Pacemaker 99
Opto-Acoustic Imaging for Breast Masses 101
Low Intensity ESWT-Corpus Cavernosum 103
Quantitative MRI Analysis of Brain 104
Part II: Key Changes in HCPCS for 2024 105
Transportation, Med/Surg Supplies, Misc & Experimental – "A" Codes 106
Medical/Surgical Supplies 106
Diagnostic Radiopharmaceuticals 106
Temporary Hospital OPPS – "C" Codes 107
Pass-Through Medical Devices 107
Complexity-Adjusted Services for ASC Payment System 109
Remote Group Psychotherapy 111
Drugs and Biologicals 113
New Technology Procedures 114
COVID-19 Specimen Collection 116
Durable Medical Equipment – "E" Codes 117
Temporary Procedures and Professional Services - "G" Codes 118
Physician Quality and Data Reporting Codes 118
Pre-exposure Prophylaxis (PrEP) to Prevent HIV Infection 119
Psychotherapy for Crisis 121
Services Addressing Health-Related Social Needs 123
Community Heath Integration (CHI) Services 126
Social Determinants of Health (SDOH) Risk Assessment 129
Principal Illness Navigation (PIN) Services 131

Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) Services 138
Behavioral Health Integration Care Management 140
Remote Interrogation Device Evaluation – Cardiovascular 141
Medicare Diabetes Prevention Program (MDPP) 143
Drugs and Biologicals – "J" Codes 145
Temporary Codes Assigned to DME Regional Carriers – "K" Codes 147
Prosthetic and Orthotic Supplies, Devices and Implants – "L" Codes 149
Medical Services – "M" Codes 150
Physician Quality and Data Reporting Codes 150
In-Home Administration of Preventive Vaccines 151
Temporary – "Q" Codes 153
Drugs and Biologicals 153
Skin Substitute Products 154
Home IVIG Administration 155
Private Payer – "S" Codes 156
National Codes for State Medicaid Agencies – "T" Codes 157
Part III: Master Table of All CPT/HCPCS Changes 158

Part I: Key Changes to CPT® for 2024

Guide to Symbols Used in this Manual

●	Indicates a new code
▲	Indicates a revised code description
►◄	Indicates a change in guideline text
✚	Indicates an add-on code
#	Indicates a resequenced code
🗲	Indicates that FDA approval is pending
★	Indicates codes which may be used for reporting telemedicine services
🔈	Indicates codes that may be used to report audio-only telemedicine services when appended by modifier 93
⃠	Indicates codes that are exempt from the use of modifier 51
⌘	Indicates duplicate proprietary laboratory analyses (PLA) codes (identical code descriptions with differing proprietary names)
⇅	Indicates Category I proprietary laboratory analyses (PLA) codes

New text in code descriptions or guidelines will be underlined.

Text removed from current code descriptions or guidelines will be ~~crossed out~~.

Release of CPT Codes

The CPT code set is published annually in late summer or early fall as both electronic data files and books. The release of CPT data files occurs annually between August 31 and the first week of September. The release of the CPT Professional publication comes several weeks later.

To meet the needs of a rapidly changing healthcare environment, the CPT code set is periodically updated throughout the year on a set schedule. Each update has both a release date and an effective date. The time between the release of the update and the effective date is considered an implementation period and is intended to allow physicians and other providers, payers, and vendors to incorporate CPT changes into their systems.

Changes to the CPT code set are meant to be applied prospectively from the effective date.

The following table from the CPT manual outlines the complete CPT code set update calendar.

CPT Code Set Update Calendar		
CPT Category/Section	**Release Timeline**	**Effective Timeline**
Category I Category II	August 31	January 1
Category III Immune Globulins, Serum, or Recombinant Products Vaccines, Toxoids	January 1 July 1	July 1 January 1
Molecular Pathology Tier 2 Administrative MAAA	April 1 July 1 October 1*	July 1 October 1 January 1
PLA	January 1 April 1 July 1 October 1	April 1 July 1 October 1 January 1

*Note that the release date may be delayed by several days due to the timing of the CPT Panel fall meeting

At times, codes are implemented outside of this set schedule in the interest of public health, such as during the COVID-19 public health emergency (PHE).

Mid-year code changes are sometimes effective too late in the year to be published in the next CPT manual production cycle. In these cases, the codes are identified as "new" when they appear in the CPT manual for the first time, even if they were effective in the prior year.

Every CPT change that is published for the first time in the 2024 CPT manual is discussed in this manual, including those with effective dates in 2023.

Also included in this manual are some CPT changes that are effective in late 2023, or on January 1, 2024, which will not be published until the 2025 CPT publication.

Evaluation and Management Services

- One new code
- 10 revised code descriptions
- Revised coding guidelines

Office or Other Outpatient Visits

Evaluation and management CPT codes and guidelines have been revised extensively over a multi-year effort between the AMA, CMS, and other interested parties. The purpose has been to update coding and payment for E/M visits so that they better reflect the current practice of medicine, are less administratively complex, and are paid more accurately.

Clarifications sought by CMS prompted the CPT Editorial Panel to add a few more revisions for 2024 that clarify the reporting of E/M services.

Time ranges have been removed from office or other outpatient visit codes (99202-99205, 99212-99215) and replaced with a single base time that must be met or exceeded. This aligns their format with other E/M codes and simplifies code selection. The below paragraph has been added to the E/M time guidelines.

> ► 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.◄

See the revised code descriptions for office or other outpatient visits below.

★▲99202 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 15~~-29 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.

★▲99203 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 30-~~44 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.

★▲99204 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 45-~~59 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.

★▲99205 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 60-~~74 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.

★▲99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 10-~~19 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.

★▲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 straightforward 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.

★▲99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 30~~-39 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.

★▲99215 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 40~~-54 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.

Nursing Facility Care

CMS sought clarification from the AMA about why CPT 99306 for initial nursing facility care and 99310 for subsequent nursing facility care had the exact same MDM and time requirements, making them appear to represent the same service.

The AMA explained that CPT 99306 is valued to include 50 minutes of intraservice time, but the code description was left unchanged in 2023 to maintain the "pattern" of time increments to make it easier for individuals to recall which code to report if they are using time-based reporting.

For 2024, CPT 99306 is revised to change the minimum time requirement from 45 minutes to 50 minutes. The associated parenthetical guideline related to prolonged services is also revised to reflect the 5-minute time increase.

▲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.

►(For services ~~60~~65 minutes or longer, use prolonged services code 99418)◄

Similarly, existing CPT 99308 for subsequent nursing facility care is revised to increase the minimum time requirement from 15 to 20 minutes. This code was valued to include 18 minutes of intraservice time, and the decision was made to round up to 20 minutes as opposed to round down to 15 minutes for the minimum time requirement.

★▲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

New CPT 99459 has been established as a practice expense only code that captures the direct practice expenses associated with performing a pelvic exam in the non-facility setting (clinical staff time associated with chaperoning a pelvic exam, plus a basic pelvic pack).

It is reportable as an add-on code with either problem-oriented or preventive E/M codes.

#✚●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)◄

No facility RVUs have been established for this code, as it is meant to cover non-facility practice expenses only.

Split or Shared Visits

The AMA has added a new subsection to the E/M Services Guidelines providing instructions for reporting split or shared visits. The new guidelines specify that when more than one physician/QHP work as a team in providing care to the patient during a single E/M service, the professional who performs a "substantive" portion of the encounter reports the service.

If code selection is reported based on time, the E/M is reported by the professional who spent more than half of the total time performing the split/shared visit.

If MDM is used as the basis for code selection, the performance of a substantive part of the MDM requires that the physician/QHP:

1. Made or approved the management plan for the *number and complexity of problems addressed at the encounter* and
2. Takes responsibility for that plan with its inherent *risk of complications and/or morbidity or mortality of patient management*.

By doing so, this provider will have performed two of the three elements of MDM required for code selection.

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.

> ► 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 or other QHP performs a substantive portion of the encounter, the physician or other 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) or other 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 or other 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 or other 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 or other 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 or other QHP if these are used to determine the reported code level by the physician or other QHP.◄

In the CY 2024 Physician Fee Schedule final rule, CMS has adopted these guidelines for Medicare use, aligning CMS and AMA definitions for split/shared visits.

For critical care visits, which do not use MDM, "substantive portion" continues to mean more than half of the total time spent by the physician and NPP performing the split/shared visit.

Multiple Evaluation & Management Services on the Same Date

A new subsection titled "Multiple Evaluation and Management Services on the Same Date" has been added to the introductory guidelines of the **Evaluation and Management** section of CPT. It outlines coding scenarios where patients have 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.

This section is specific to hospital inpatient, observation, or nursing facility E/M codes.

> ► 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 or other QHP or another physician or other 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 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.

Emergency department (ED) and services in other settings (same or different facilities): Time spent in an ED by a physician or other 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.

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.

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.◄

Hospital Inpatient and Observation Care

Guidelines have been added to the CPT subsection for inpatient or observation care services to clarify proper reporting for patients who are admitted and discharged on the same date. These are not new rules, but rather a helpful summary of existing rules.

> ► The following codes are used to report hospital inpatient or observation care services provided to patients admitted and discharged on the same date of service when the stay is more than eight hours. These services are only used by the physician or other qualified health care professional team who performs both the initial and discharge services. Other physicians and other qualified health care professionals may report 99221, 99222, 99223, as appropriate.
>
> When a patient receives hospital inpatient or observation care for fewer than eight hours, only the initial hospital inpatient or observation care codes (99221, 99222, 99223) may be reported for the date of admission. Hospital or observation discharge day management codes (99238, 99239) may not be reported. When a patient receives hospital inpatient or observation care for a minimum of eight hours and is discharged on the same calendar date, observation or inpatient care services (including admission and discharge services) codes (99234, 99235, 99236) may be reported. Codes 99238, 99239 are not reported.
>
> For patients admitted to hospital inpatient or observation care and discharged on a different date, see 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239.
>
> Codes 99234, 99235, 99236 require two or more visits on the same date of which one of these visits is an initial admission and another being a discharge. For a patient admitted and discharged at the same visit (ie, one visit), see 99221, 99222, 99223. Do not report 99238, 99239 in conjunction with 99221, 99222, 99223 for admission and discharge services performed on the same date.◄

The below table has been added to the manual to assist with proper code selection depending on the length of stay and discharge date.

Length of Stay	Discharged On	Report Codes
<8 hours	Same calendar date as initial hospital inpatient or observation care service	99221, 99222, 99223
8 or more hours	Same calendar date as initial hospital inpatient or observation care service	99234, 99235, 99236
<8 hours	Different calendar date as initial hospital inpatient or observation care service	99221, 99222, 99223
8 or more hours	Different calendar date as initial hospital inpatient or observation care service	99221, 99222, 99223 and 99238, 99239

Anesthesia

- No changes for 2024

Integumentary System

- No changes for 2024

Musculoskeletal System

- Four new codes
- Six revised codes

Thoracic Vertebral Body Tethering

Anterior vertebral body tethering (VTB) is a non-fusion spinal procedure intended for surgical correction of scoliosis in growing children.

VTB immediately corrects spinal curvature and increases mobility and flexibility. As opposed to posterior spinal fusion (PSF), tethering allows for additional correction based on a child's potential remaining growth.

This procedure is often performed by two surgeons, one who performs the approach, and a second that attaches screws to specific vertebral bodies on the spine before connecting them using a flexible polyethylene-braided cord called a tether.

Three new CPT codes are established for this procedure for 2024 when performed on the thoracic spine. Codes 22836 and 22837 are reported for anterior thoracic vertebral body tethering based on the number of vertebral segments involved in the procedure.

#●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 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)◄

New code 22838 is reported for revision, replacement, or removal of a previously placed tether.

#●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)◄

If these procedures are performed by two surgeons as co-surgeons, each would report the code with modifier 62 as long as both surgeons continue to work together as primary surgeons.

Vertebral body tethering was previously reported with Category III CPT codes 0656T and 0657T. These codes will continue to be used to report anterior lumbar or thoracolumbar vertebral body tethering, along with new code 0790T for revision, replacement, or removal of lumbar or thoracolumbar tethering, as discussed on page **83** of this manual.

SI Joint Arthrodesis

New code 27278 describes percutaneous placement of an intra-articular stabilization device into the sacroiliac (SI) joint using a minimally invasive technique that does not transfix the SI 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)◄

This differs from existing CPT 27279, which describes placement of an internal fixation device that passes through the ilium, across the sacroiliac joint, and into the sacrum, thus transfixing the sacroiliac joint.

This code is replacing Category III CPT 0775T, which is deleted for 2024.

~~0775T~~ ~~Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s])~~

Bunion Correction

The six existing CPT codes shown below for bunion correction procedures are editorially revised to clarify their intended use. Rather than including the term "bunionectomy" within parenthesis as if an example of how the procedure is performed, the code descriptions now specifically state "with bunionectomy." There is no change to how these codes are used.

A new parenthetical guideline has also been added beneath CPT 28297 for bunionectomy with arthrodesis which instructs that if arthrodesis is performed without hallux valgus correction, existing CPT 28740 (Arthrodesis, midtarsal or tarsometatarsal, single joint) should be reported.

▲28292 Correction, hallux valgus with ~~(~~bunionectomy~~)~~, with sesamoidectomy~~,~~ when performed; with resection of proximal phalanx base, when performed, any method

▲28296 with distal metatarsal osteotomy, any method

#▲28295 with proximal metatarsal osteotomy, any method

▲28297 with first metatarsal and medial cuneiform joint arthrodesis, any method

►(For first metatarsal-cuneiform joint fusion without concomitant removal of the distal medial prominence of the first metatarsal for hallux valgus correction, use 28740)◄

▲28298 with proximal phalanx osteotomy, any method

▲28299 with double osteotomy, any method

Respiratory System

- Two new codes

Posterior Nasal Nerve Ablation

HCPCS code C9771 "Nasal/sinus endoscopy, cryoablation nasal tissue(s) and/or nerve(s), unilateral or bilateral" was established by CMS in 2021 through the new technology application process.

This code described the first energy-based ablation technology that was FDA cleared for this type of procedure. Posterior nasal nerve (PNN) ablation is an endoscopic procedure that utilizes energy-based neurolysis to treat chronic rhinitis.

The AMA has established two new CPT codes for 2024, one to describe radiofrequency ablation and one to describe cryoablation of the posterior nasal nerve.

#●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)◄

These codes describe bilateral procedures. If performed unilaterally, the codes should be reported with reduced service modifier 52.

Due to the establishment of these new codes, existing HCPCS C9771 is deleted for 2024, as shown on page **114** of this manual.

Cardiovascular System

- Eight new codes

Phrenic Nerve Stimulation System

A new subsection and eight new CPT codes have been added to the **Cardiovascular** section of the CPT manual to report phrenic nerve stimulator procedures. These new codes replace 10 existing Category III CPT codes which are deleted for 2024.

These systems are used to treat moderate to severe central sleep apnea (CSA) for patients with concomitant conditions such as heart failure with reduced ejection fraction.

Insertion of a phrenic nerve stimulation system includes a pulse generator and a stimulation lead. Insertion of the pulse generator and lead is reported with new CPT 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.

#●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

Rarely, a separate sensing lead may be needed to augment system function. The sensing lead is placed transvenously into the azygos vein. When performed at time of system insertion, this reported with new add-on code 33277.

If a sensing lead is placed at a time other than the initial insertion of the system, it must be reported with unlisted CPT 33999 (Unlisted procedure, cardiac surgery).

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

New codes 33278-33280 describe removal of the entire system, lead(s) only, or pulse generator only.

#●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

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

Repositioning of stimulator lead(s) is reported with 33281. This is only reportable if performed in a separate encounter from insertion or replacement of the system/lead(s) and is reportable once per patient per day.

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

New codes 33287 and 33288 are used to report removal and replacement of pulse generator or lead(s).

#●33287 Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator

#●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)

Each of these codes includes vessel catheterization and all imaging guidance required for the procedure, which is not separately reportable.

Initial system placement includes initiation of diagnostic mode and associated system evaluation. Subsequent therapeutic activation and programming/ interrogation of the system is reported with new codes 93150-93153, found in the **Medicine** section of the CPT manual, and discussed on page **63** of this manual.

The existing Category III CPT codes for insertion, removal, repositioning, and replacement of phrenic nerve stimulation systems that are deleted for 2024 are shown below.

~~0424T~~ ~~Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator)~~

~~0425T~~ ~~Insertion or replacement of neurostimulator system for treatment of central sleep apnea; sensing lead only~~

~~0426T~~ ~~Insertion or replacement of neurostimulator system for treatment of central sleep apnea; stimulation lead only~~

~~0427T~~ ~~Insertion or replacement of neurostimulator system for treatment of central sleep apnea; pulse generator only~~

~~0428T~~ ~~Removal of neurostimulator system for treatment of central sleep apnea; pulse generator only~~

~~0429T~~ ~~Removal of neurostimulator system for treatment of central sleep apnea; sensing lead only~~

~~0430T~~ ~~Removal of neurostimulator system for treatment of central sleep apnea; stimulation lead only~~

~~0431T~~ ~~Removal and replacement of neurostimulator system for treatment of central sleep apnea, pulse generator only~~

~~0432T~~ ~~Repositioning of neurostimulator system for treatment of central sleep apnea; stimulation lead only~~

~~0433T~~ ~~Repositioning of neurostimulator system for treatment of central sleep apnea; sensing lead only~~

Hemic and Lymphatic Systems

- No changes for 2024

Mediastinum and Diaphragm

- No changes for 2024

Digestive System

- No changes for 2024

Urinary System

- One new code

Cystopic Drug Delivery

Existing Category III CPT 0499T is deleted for 2024 due to the establishment of a permanent Category I CPT for cystourethroscopy with mechanical urethral dilation and drug delivery.

~~0499T~~ ~~Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis, including fluoroscopy, when performed~~

New CPT 52284 describes the same procedure, which involves pre-dilation of a urethral stricture with a balloon catheter followed by placement of a separate drug-coated balloon catheter for therapeutic drug delivery.

●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)◄

This service is typically performed under general anesthesia in the facility setting. It requires a retrograde urethrogram to appropriately measure the length of stricture, which is not separately reportable. Fluoroscopy is used throughout the procedure to confirm appropriate balloon placement, which is also not separately reportable.

Male Genital System

- No changes for 2024

Female Genital System

- One new code

Transcervical Ablation of Uterine Fibroids

Existing Category III CPT 0404T is deleted for 2024 due to the establishment of a permanent Category I CPT for transcervical ablation of uterine fibroids.

~~0404T~~ ~~Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency~~

New CPT 58580 describes this procedure, which involves ultrasound guided radiofrequency ablation of uterine fibroids via a transcervical approach. Existing code 58674 describes a similar procedure when performed via laparoscopic approach.

●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)◄

This service is typically performed under general anesthesia in the facility setting.

The CPT has been added in a new subsection of the CPT manual titled "Other Procedures" within the Corpus Uteri section of the **Female Genital System**, along with existing CPT codes 58353 and 58356 for thermal and cryoablation procedures, which have been resequenced to this new section of the manual from the "Introduction" subsection.

Maternity Care and Delivery

- No changes for 2024

Endocrine System

- No changes for 2024

Nervous System

- Six new codes
- Four revised code descriptions

Skull-Mounted Cranial Neurostimulator

Three new CPT codes are established for reporting the insertion, revision, replacement, or removal of a skull-mounted cranial neurostimulator pulse generator or receiver.

These codes describe a cranial neurostimulator that is placed within a craniectomy in the patient's skull, as opposed to existing CPT codes 61885-61886 which describe cranial neurostimulators that are placed in subcutaneous pockets in the infraclavicular area. Previously, skull-mounted placement would have been reported with unlisted CPT 64999 (Unlisted procedure, nervous system).

CPT 61889 describes insertion of the pulse generator or receiver, including craniectomy or craniotomy. This major surgery is typically performed in the inpatient setting, and the CPT has been designated as "inpatient only" by Medicare.

●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)

Codes 61891 and 61892 are used to report revision, replacement, or removal of skull-mounted cranial neurostimulator pulse generators or receivers. CPT 61892 for removal includes repair of the skull (cranioplasty) when performed, which is not separately reportable.

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

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

Spinal and Peripheral Nerve Neurostimulator Services

Existing CPT 63685 for insertion or replacement of a spinal neurostimulator pulse generator or receiver was identified in a high-volume growth screen and recommended for review by the CPT Editorial Panel. Several new and revised CPT codes resulted from the review.

A neurostimulator system includes an implanted pulse generator or receiver which delivers electrical stimulation via an electrode array. The pulse generator or receiver may be integrated with the electrode array (single-component implant) or have a detachable connection to the electrode array (two or more component implant).

Existing CPT codes 63685 and 63688 for spinal neurostimulator procedures are revised to specifically describe multiple component implants which require a connection between the electrode array and pulse generator.

New parenthetical references point to Category III CPT codes for spinal or sacral electrode arrays with integrated neurostimulators, which are established for 2024, as discussed on page **91**.

▲63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver~~, direct or inductive coupling~~, requiring pocket creation and connection between electrode array and pulse generator or receiver

►(For insertion or replacement of spinal percutaneous electrode array with integrated neurostimulator, use 0784T)◄

▲63688 Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array

►(For revision or removal of spinal percutaneous electrode array and integrated neurostimulator, use 0785T)◄

►(For revision or removal of sacral percutaneous electrode array and integrated neurostimulator, use 0787T)◄

Existing codes 64590 and 64595 for peripheral or gastric neurostimulators are similarly revised to describe multiple component implants. Additionally, these codes are revised to clarify that they also include sacral nerve neurostimulators.

▲64590 Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, ~~direct or inductive coupling~~ requiring pocket creation and connection between electrode array and pulse generator or receiver

▲64595 Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array

Three new codes have been established for reporting integrated (single-component) peripheral nerve neurostimulators. Codes 64596 and 64597 describe insertion or replacement of percutaneous electrode arrays with integrated neurostimulator. They are reported per electrode array. These codes include imaging guidance, which is not separately reportable.

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

✚●64597 each additional electrode array (List separately in addition to code for primary procedure)

►(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)◄

Revision or removal of peripheral nerve integrated neurostimulators is reported with new CPT 64598.

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

New parenthetical guidelines have been added for both existing and new peripheral nerve neurostimulator codes which state that insertion of neurostimulators or electrode arrays without a named target nerve, such as for field stimulation, should be reported with unlisted CPT 64999.

Eye and Ocular Adnexa

- One new code

Suprachoroidal Injection

Existing Category III CPT 0465T is deleted for 2024 due to the establishment of a permanent Category I CPT for suprachoroidal injection of medication.

~~0465T~~ ~~Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)~~

New CPT 67516 describes injection of medication into the suprachoroidal space. The work involved in this procedure is different from that of other intraocular or peri-ocular injections and requires precise placement of the needle tip into the potential suprachoroidal space.

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

►(Report medication separately)◄

There is currently only one FDA-approved medication for this procedure, triamcinolone acetonide, and it is approved for only one indication, macular edema associated with uveitis.

The relevant HCPCS code for the related medication (reported separately) is J3299 (Injection, triamcinolone acetonide (Xipere), 1 mg).

Auditory System

- No changes for 2024

Radiology

- Five new codes
- One deleted code

Pelvimetry

CPT 74710 for pelvimetry has been deleted with no replacement due to low utilization.

Pelvimetry is used to compare the capacity of the pelvis to the size of an infant's head to discover any disproportion and determine the need for a C-section.

However, radiographic pelvimetry is not used often in modern obstetrics because of the risks associated with radiation.

If performed, unlisted CPT 76499 should be used (Unlisted diagnostic radiographic procedure).

~~74710~~ ~~Pelvimetry, with or without placental localization~~

►(74710 has been deleted)◄

Fractional Flow Reserve with CT

Four existing Category III CPT codes for non-invasive estimation of coronary fractional flow reserve (FFR) derived from coronary CTA data are deleted for 2024 due to the establishment of a permanent Category I CPT for this service.

~~0501T~~ ~~Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, with anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report~~

~~0502T~~ ~~data preparation and transmission~~

~~0503T~~ ~~analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model~~

~~0504T~~ ~~anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report~~

New CPT 75580 describes coronary FFR estimation using augmentative software analysis of coronary CTA data (FFRCT), also known by the trade name HeartFlow.

FFRCT calculates the severity of coronary artery disease in symptomatic patients and is used to enhance physician decision-making for treatment planning either for medical therapy or revascularization after the initial coronary CTA is obtained. Its use may avoid the need for an invasive coronary angiogram procedure.

●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)◄

FFRCT is often performed on a separate date from the CTA exam. It requires separate training and expertise such that the interpretation and report are often performed by different providers at different times. If performed on the same day, both the CTA exam and FFRCT may be reported.

The AMA suggests that the standard practice is changing for patients with active chest pain, as the predictive accuracy of the CT angiogram and FFRCT is far more accurate than stress testing. In most centers, stress testing is being replaced by FFRCT to discriminate if there is an important lesion in the coronary arteries.

Unlike the predecessor codes, the new CPT reports the complete FFRCT service, as opposed to individual CPT codes describing various components of the analysis.

The professional and technical components of CPT 75580 may be furnished by different physicians or facilities, or they may be furnished together as a global service.

Intraoperative Cardiac Ultrasound

Existing CPT 76998 (Ultrasound guidance, intraoperative) was identified in a screen for codes with Medicare utilization over 20,000 and has never previously been reviewed by the Relative Value Update Committee (RUC).

It was determined that many different specialties utilize this code, including Cardiothoracic surgery, general surgery, breast surgery, urology, interventional cardiology, interventional radiology, and vascular surgery.

Based on the variability of intraoperative ultrasound for each specialty, with differences in the typical patient and physician work, it was decided that each society would submit applications for new code(s), as needed, to carve out the work currently reported with 76998 until the code was no longer needed or until it was clear what the final dominant use of 76998 was so that a survey could be conducted.

Several scenarios where code 76998 had been reported were addressed by the CPT Editorial Panel in 2020 and 2021, including the addition of instructional parenthetical references that restrict the use of imaging guidance with vein ablation procedures, addition of new codes that bundled imaging guidance for urological procedures, and a panel determination about correct coding for intraoperative intra-abdominal diagnostic ultrasound.

For 2024, four new codes are established to report intracardiac ultrasound procedures. Once these codes are in use, it is expected that most remaining utilization of CPT 76998 will be related to breast surgery, allowing for the code to be resurveyed by those providers.

New code 76984 describes intraoperative diagnostic ultrasound of the thoracic aorta.

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

This procedure is performed in the operating room through an open chest, where the ultrasound probe is placed directly on the thoracic aorta to obtain targeted images of the aorta to determine if plaque and/or calcium is present and if so, decide on alternative cannulation strategies and/or grafting sites.

This is typically performed because a transesophageal echocardiogram (TEE) could not fully visualize the thoracic aorta due to air in the trachea or because there are contraindications to TEE during surgery.

New codes 76987-76989 describe intraoperative echocardiography. This procedure is rarely performed and describes ultrasound image acquisition performed in the operating room through an open chest where the ultrasound probe is placed directly on the patient's beating heart.

●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

This service would typically be performed on infants and is only for patients with congenital defects and where TEE is contraindicated.

It is common for a cardiologist to perform a portion of the procedure. For this reason, the codes were developed to allow for either one provider (typically the cardiothoracic surgeon) to perform all aspects of the intraoperative ultrasound (CPT 76987, image acquisition and interpretation) or for two providers (such as a cardiothoracic surgeon and a cardiologist) to report their individual components of the procedure (CPT 76988, image acquisition, and CPT 76989, interpretation and report).

Pathology and Laboratory

- 93 new codes
- 15 deleted codes
- 27 revised code descriptions

Molecular Pathology Editorial Language Revisions

Nine existing CPT codes for Tier 1 and Tier 2 molecular pathology tests are editorially revised to update gene names and replace the term "mental retardation" with "intellectual disability."

These changes are strictly editorial in nature and do not impact how the codes are used. Each of the revised codes is shown below.

Note: Due to the very long descriptions for Tier 2 Molecular Pathology codes, only the portion of the code description that is being revised is displayed below. See CPT 2024 for complete code descriptions.

▲81171 AFF2 (~~AF4/FMR2 family, member 2~~ALF transcription elongation factor 2 [FMR2]) (eg, fragile X ~~mental retardation~~ intellectual disability 2 [FRAXE]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles

▲81172 characterization of alleles (eg, expanded size and methylation status)

▲81243 FMR1 (fragile X ~~mental retardation~~ messenger ribonucleoprotein 1) (eg, fragile X ~~mental retardation~~ syndrome, X-linked intellectual disability [XLID]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles

▲81244 characterization of alleles (eg, expanded size and methylation status)

▲81403 Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)

ARX (aristaless related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked ~~mental retardation~~ intellectual disability), duplication/deletion analysis

▲81404 Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)

ARX (aristaless related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked ~~mental retardation~~ intellectual disability), full gene sequence

ZNF41 (zinc finger protein 41) (eg, X-linked ~~mental retardation~~ intellectual disability 89), full gene sequence

▲81405 Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis)

FTSJ1 (FtsJ RNA ~~methyltransferase homolog 1 [E. coli]~~2'-O-methyltransferase 1) (eg, X-linked ~~mental retardation~~ intellectual disability 9), duplication/deletion analysis

▲81406 Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons)

FTSJ1 (FtsJ RNA ~~methyltransferase homolog 1 [E. coli]~~2'-O-methyltransferase 1) (eg, X-linked ~~mental retardation~~ intellectual disability 9), full gene sequence

▲81407 Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)

KDM5C (lysine ~~[K]-specific~~ demethylase 5C) (eg, X-linked ~~mental retardation~~ intellectual disability), full gene sequence

Tumor Genomics Testing

The family of codes and introductory guidelines for tumor genomics testing are revised to reflect current practice in genomic sequencing technology for somatic mutation and cancer treatment.

Existing codes 81445-81456 describe genomic sequence analysis of solid organ neoplasm or hematolymphoid neoplasm/disorder using DNA, RNA, or combined DNA/RNA analysis. These codes are editorially revised to standardize naming convention in conjunction with the establishment of new CPT codes 81457-81464, shown on the following pages.

▲81445 ~~Targeted genomic sequence analysis panel, s~~Solid organ neoplasm, genomic sequence analysis panel, 5-50 genes ~~(eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET)~~, interrogation for sequence variants and copy number variants or rearrangements, if performed; DNA analysis or combined DNA and RNA analysis

▲81449 RNA analysis

▲81450 ~~Targeted genomic sequence analysis panel, h~~Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes ~~(eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NOTCH1, NPM1, NRAS)~~, interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis

▲81451 RNA analysis

▲81455 ~~Targeted genomic sequence analysis panel, s~~Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, ~~(eg, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MET, MLL, NOTCH1, NPM1, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET),~~ interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis

▲81456 RNA analysis

New codes 81457-81459 are established for reporting solid organ neoplasm genomic sequence analysis including microsatellite instability (MSI) testing. CPT 81458 includes both MSI and copy number variant (CNV) testing. CPT 81459 includes MSI, CNV, tumor mutation burden (TMB), and rearrangements.

●81457	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, microsatellite instability
●81458	DNA analysis, copy number variants and microsatellite instability
●81459	DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements

New codes 81462-81464 describe genomic sequence analysis of cell-free nucleic acid (e.g., plasma). Code 81462 is reported for DNA or combined DNA/RNA analysis and includes CNV and rearrangements. Code 81463 is reported for DNA analysis with CNV and MSI. Code 81464 is reported for DNA or DNA/RNA analysis with CNV, MSI, TMB, 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	DNA analysis, copy number variants, and microsatellite instability
#●81464	DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements

New definitions, including for MSI, CNV, cell-free nucleic acid, rearrangements, and TMB, among others, have been added to the introductory guidelines of this section in the CPT manual. A new table has also been added to the guidelines which lists all 12 CPT codes and outlines the specimen and test types included in each code.

The new definitions and table are shown on the following pages.

Below are the new definitions added to the CPT manual.

►**Cell-free nucleic acid**: DNA or RNA released into the blood and other body fluids. Cell-free nucleic acid released from fetal cells can be sampled for non-invasive prenatal testing (NIPT) while that released from tumor cells can be sampled for cancer, sometimes referred to as tumor liquid biopsy.

Copy number variants (CNVs): structural changes in the genome which are composed of large deletions or duplications. CNVs can be found in the germline but can also occur in somatic cells. See also Duplication/Deletion (Dup/Del). Duplications may also be referred to as amplifications.

Duplication/Deletion (Dup/Del): terms that are usually used together with the "/" to refer to molecular testing, which assesses the dosage of a particular genomic region. The region tested is typically of modest to substantial size, from several dozen to several million or more nucleotides. Normal gene dosage is two copies per cell, except for the sex chromosomes (X and Y). Thus, zero or one copy represents a deletion and three (or more) copies represent a duplication.

Massively parallel sequencing (MPS): high-throughput method used to determine a portion of the nucleotide sequences in an individual patient's genome, utilizing advanced (non-Sanger) sequencing technologies that are capable of processing multiple DNA and/or RNA sequences in parallel. While other technologies exist, next-generation sequencing (NGS) is a common technique used to achieve MPS.

Microsatellite instability (MSI): a type of DNA hypermutation or predisposition to mutation in which replication errors are not corrected due to defective DNA mismatch repair (dMMR) mechanism. MSI manifests as insertions or deletions in short tandem repeat (STR) (defined in the molecular pathology guidelines) alleles and can be identified by changes in the DNA repeat sequence length.

Rearrangements: structural chromosomal variations such as deletions, insertions, inversions (defined in the molecular pathology guidelines), or translocations (defined in the molecular pathology guidelines) that bring together genetic material that is not normally adjacent in the unmodified genome. It can manifest as abnormal gene expression or as an abnormal fusion product at the RNA and/or protein level. Rearrangement can also refer to the process by which immunoglobulin and T cell receptor genes are normally modified.

Tumor mutational burden (TMB): the number of somatic mutations detected per million bases (Mb) of genomic sequence investigated from a cancer specimen. It is usually obtained from analysis using a next generation sequencing method. It is considered a biomarker to guide immunotherapy decisions for patients with cancer.◄

Below is the new table outlining components of tumor genomics CPT codes.

Code	Specimen Source			Nucleic Acid	Sequence Variants	Copy Number Variants	Micro-satellite Instability	Tumor Mutation Burden	Rearrange ments
	Solid Organ	Hemato-lymphiod	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	RNA	X		X		
81458	X		No	RNA	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	RNA	X	X	X		
81464	X		Yes	DNA or DNA/RNA	X	X	X	X	X

Multianalyte Assays with Algorithmic Analysis (MAAAs)

Multianalyte Assays with Algorithmic Analysis (MAAAs) are procedures that utilize multiple results from panels of analyses of various types. They include algorithmic analysis using the results of the assays as well as other patient information which is reported as a numeric score or probability.

This risk score or other value represents a new and distinct medical property that is of medical significance and differentiates MAAAs from genomic sequencing procedures and other molecular multianalyte assays. MAAAs are typically unique to a single clinical laboratory or manufacturer.

New CPT 81517 is used to report the Enhanced Liver Fibrosis (ELF)™ test by Siemens Healthcare Diagnostics.

●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

►(Do not report 81517 in conjunction with 83520 for identification of biomarkers included for liver disease analysis)◄

This code replaces administrative MAAA code 0014M which is deleted for 2024.

~~0014M 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~~

Administrative MAAA codes are used to facilitate accurate reporting of MAAA services. The minimum standard for inclusion is that an analysis is generally available for patient care. The AMA has not reviewed procedures in the administrative coding set for clinical utility.

New administrative MAAA code 0019M was established effective October 1, 2023 for reporting the SOMAmer® test by SomaLogic and is published in the CPT manual for the first time in 2024. This test is used to identify residual cardiovascular risk (RCVR) using a multianalyte assay with algorithm.

●0019M Cardiovascular disease, plasma, analysis of protein biomarkers by aptamer-based microarray and algorithm reported as 4-year likelihood of coronary event in high-risk populations

Chemistry

New CPT 82166 is established for reporting an anti-mullerian hormone (AMH) assay.

●82166 Anti-mullerian hormone (AMH)

Important: This test is likely built in the chargemaster using an unspecified CPT, such as 83520 "Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified." It is recommended that you check your laboratory information system to confirm how this test is currently reported, if performed.

Immunology

Four new CPTs are established in the Immunology section of CPT for reporting acetylcholine receptor binding, blocking, and modulating antibodies, as well as muscle-specific kinase (MuSK) antibodies.

#●86041 Acetylcholine receptor (AChR); binding antibody

#●86042 Acetylcholine receptor (AChR); blocking antibody

#●86043 Acetylcholine receptor (AChR); modulating antibody

#●86366 Muscle-specific kinase (MuSK) antibody

Important: These tests are likely built in the chargemaster using an unspecified CPT, such as 83519 “Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, by radioimmunoassay (eg, RIA).” It is recommended that you check your laboratory information system to confirm how these tests are currently reported, if performed.

Microbiology

New CPT 87523 has been established to report a quantitative nucleic acid assay for Hepatitis D for virus confirmation.

●87523 Infectious agent detection by nucleic acid (DNA or RNA); hepatitis D (delta), quantification, including reverse transcription, when performed

CPT 87593 is used for reporting PCR orthopoxvirus virus testing (e.g., monkeypox). This code was established effective July 26, 2022, due to an immediate need for the code to be available and is published in the CPT manual for the first time in 2024.

●87593 Infectious agent detection by nucleic acid (DNA or RNA); Orthopoxvirus (eg, monkeypox virus, cowpox virus, vaccinia virus), amplified probe technique, each

Important: These tests may be built in the chargemaster using unspecified CPTs 87798 "Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism" and 87799 "Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; quantification, each organism." It is recommended that you check your laboratory information system to confirm how these tests are currently reported, if performed.

Proprietary Laboratory Analysis (PLA) Codes

Proprietary Laboratory Analysis (PLA) codes are alpha-numeric CPT codes ending in the letter "U." They describe proprietary clinical laboratory tests which are either provided by a single laboratory or are licensed and marketed to multiple providing laboratories.

The PLA code set includes advanced diagnostic laboratory tests (ADLTs) and clinical diagnostic laboratory tests (CDLTs). They include a range of medical laboratory tests including, but not limited to, multianalyte assays with algorithmic analyses (MAAAs) and genomic sequencing procedures (GSPs). The descriptor nomenclature follows existing code conventions where possible.

New PLA codes are approved quarterly. Each quarter, new codes are published on the AMA website: https://www.ama-assn.org/practice-management/cpt/cpt-pla-codes

When a PLA code becomes available to report a given proprietary lab test, the PLA code takes precedence, and the test should not be reported with any other CPT code.

PLA codes are added to the CPT manual each year, but due to their quarterly release cycle, not every active code will be found in the manual. All codes that are included in the CPT manual are also included in Appendix O of the manual along with the test's proprietary name.

As of October 1, 2023, there are 378 active PLA codes. There were 62 new codes established throughout CY 2023 which will be published for the first time in the CPT 2024 manual. Fifteen PLA codes were deleted and ten were revised throughout 2023.

An additional 19 new codes are effective January 1, 2024, but were not released until September 29, 2023, and will not be published until the 2025 CPT Manual. Two codes are also revised effective January 1, 2024, and the revisions will not be published until the 2025 CPT manual.

Each of these codes is included in the table provided with this manual.

Medicine

- 32 new codes
- 64 deleted codes
- Five revised code descriptions

Immune Globulins, Serum, or Recombinant Products

To facilitate vaccine reporting, CPT codes for new vaccine products are released following the semi-annual "early release" schedule on January 1 and July 1.

For the CPT 2024 code set, the AMA has further updated this process to not only include vaccine products, but also immunization products. For the purposes of CPT coding, "immunization" includes vaccines/toxoids, immune globulins, and serum or recombinant products.

In recognition of public health interest in immunization products, the AMA has agreed that new immunization product codes should be published prior to FDA approval. These codes are indicated with the (⚡) symbol in the CPT manual and will be tracked by the AMA to monitor FDA approval status. Once the FDA status changes to approval, the (⚡) symbol will be removed.

An emergent or critical distribution and recommended administration of an immunization for immediate use may necessitate an additional "electronic" publication date for an immunization code apart from the established July 1 and January 1 early release dates, as is the case with the two codes shown below.

CPT codes 90380 and 90381 were made effective July 17, 2023 to report a respiratory syncytial virus (RSV) monoclonal antibody product (trade name Beyfortus). They are published in the CPT manual for the first time in 2024.

●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

This product was approved by the FDA on July 17, 2023 for prevention of RSV in newborns or infants born during, or entering their first RSV season, and for children up to 24 months of age who remain at risk of severe RSV disease through their second RSV season.

In another special release on October 6, 2023, the AMA established new CPT codes 96380 and 96381 specific to the administration of this product, as shown below. These codes will not be published in the CPT manual until 2025.

#●96380 Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional

►(Report 96380 for administration of respiratory syncytial virus, monoclonal antibody, seasonal dose [90380, 90381])◄

#●96381 Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection

►(Report 96381 for administration of respiratory syncytial virus, monoclonal antibody, seasonal dose [90380, 90381])◄

All new immunization codes are published as they are released on the AMA website: https://www.ama-assn.org/practice-management/cpt/category-i-immunization-codes

Immunization Administration, Vaccines & Toxoids

COVID-19 Vaccines and Administration

The AMA has indicated that there is no longer a need for the coding granularity of individual administration codes for every COVID-19 vaccine product. The code set for COVID-19 vaccines and administration have been revised to align with existing codes for other vaccine products and administrations.

Three new CPT codes have been established effective September 11, 2023 for Pfizer COVID-19 vaccines, and two new codes are established for Moderna COVID-19 vaccines, as shown in the two tables below.

Pfizer COVID-19 Vaccine Products		
Code	**Descriptor**	**Age Range**
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

Moderna COVID-19 Vaccine Products		
Code	**Descriptor**	**Age Range**
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

New CPT 90480 was established effective September 11, 2023 for reporting the administration of *any* COVID-19 vaccine for *any* patient (pediatric or adult), replacing all previously approved specific vaccine administration codes.

#●90480 Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose

As with previous, more granular COVID-19 vaccine administration codes, counseling is included in code 90480 and should not be reported separately.

All previous COVID-19 vaccine product and administration codes are deleted from the CPT code set effective November 1, 2023, except for 91304 for the Novavax product. This code was revised effective August 14, 2023, and remains available for use.

#▲91304 Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, ~~preservative free,~~ 5 mcg/0.5 mL dosage, for intramuscular use

Given that the COVID-19 vaccine product and administration codes have been streamlined and most existing codes have been deleted, Appendix Q is also deleted from the CPT code set effective November 1, 2023.

***Note that all these changes were approved and made effective in late 2023, so none of them will appear in the CPT manual until the 2025 publication.

The table accompanying this manual lists the previous 47 COVID-19 vaccine administration codes and 17 vaccine product codes which are now deleted.

Other Vaccine Products

A few other vaccine product codes established via midyear releases are published in the CPT manual for the first time in 2024.

New codes 90611 and 90622 describe smallpox and monkeypox vaccine products and were established effective July 26, 2022.

#●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

New code 90679 was established effective May 3, 2023 for reporting an adjuvanted RSV vaccine product (trade name AREXVY).

●90679 Respiratory syncytial virus vaccine, preF, recombinant, subunit, adjuvanted, for intramuscular use

Three vaccine product codes are brand new for 2024.

New CPT 90589 is for a live chikungunya virus vaccine. Code 90623 is for a meningococcal pentavalent vaccine. CPT 90863 is another new code for an RSV vaccine product (trade name ABRYSVO).

#↗●90589 Chikungunya virus vaccine, live attenuated, for intramuscular use

#↗●90623 Meningococcal pentavalent vaccine, conjugated Men A, C, W, Y- tetanus toxoid carrier, and Men B-FHbp, for intramuscular use

#↗●90683 Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use

Auditory Osseointegrated Device Services

New codes 92622 and 92623 are established for reporting analysis, programming, and verification of an auditory osseointegrated sound processer. No codes existed previously to report this service, which has been reported with an unlisted code.

The new codes are time-based, with CPT 92622 describing the first 60 minutes and CPT 92923 reported for each additional 15 minutes.

●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)◄

These services include evaluating the attachment of the processor, device feedback calibration, device programming, and verification of the processor performance.

They should be used for subsequent reprogramming only, when performed. Programming at the time of initial device placement is not separately reportable.

Coronary Lithotripsy

Category III CPT 0715T was established July 1, 2022 for reporting percutaneous coronary lithotripsy. This code is deleted for 2024 due to the establishment of permanent Category I CPT 92972 to describe this service.

~~0715T~~ ~~Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)~~

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

Percutaneous transluminal coronary lithotripsy may be reported using 92972 in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975, as appropriate.

It is also reportable with the equivalent HCPCS C-codes for interventions performed with drug eluting stents (C9600-C9608).

Phrenic Nerve Stimulation System

As discussed on page **26** of this manual, eight new Category I CPT codes have been established in the **Cardiovascular** section of CPT for reporting the insertion, removal, replacement, or repositioning of phrenic nerve stimulation systems used for treatment of severe central sleep apnea. The codes replace a set of Category III CPT codes that are deleted for 2024.

Similary, four new Category I CPT codes are established for reporting activation, interrogation, and programming of phrenic nerve stimulation systems. These are also replacing deleted Category III CPT codes, as shown below.

~~0434T~~ ~~Interrogation device evaluation implanted neurostimulator pulse generator system for central sleep apnea~~

~~0435T~~ ~~Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; single session~~

~~0436T~~ ~~Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; during sleep study~~

The four new codes differ in a few ways from the Category III codes.

First, new CPT 93150 describes therapy activation of a phrenic nerve stimulator system. This is performed once, after 30 days from implantation, to allow for lead stabilization.

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

Activation includes device evaluation and programming services including rate, pulse amplitude, pulse duration, configuration of waveform, battery status, electrode selection output modulation, cycling, impedance, and patient compliance measurements (e.g., hours of therapy, sleeping position, and activity [sleep activity, awake activity, time in a sleep position].

Subsequent interrogation and programming is reported with CPT 93151, or CPT 93153 for interrogation only. This may be performed to evaluate device function and to optimize performance incrementally.

For patients that require programming during a polysomnogram, this is reported with new CPT 93152. Report this code once, regardless of how many programming changes are made over the course of the polysomnogram.

#●93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system
#●93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography
#●93153	Interrogation without programming of implanted phrenic nerve stimulator system

Venography for Congenital Heart Defects

Five new add-on codes have been established for reporting venography services performed during cardiac catheterization for congenital heart defects. Venography of these congenital defects requires catheter placement(s) distinct from those required for congenital left and right heart catheterization. The new codes include catheter placement in the specific venous structure(s) being imaged in addition to venography and radiologic supervision and interpretation.

Code 93584 is reported for venography of an anomalous or persistent superior vena cava (SVC). Catheter placement in a normal SVC is considered part of standard congenital cardiac catheterization and is reported with existing CPT 75827.

For coding purposes, the term "anomalous/persistent left or right SVC" refers to a second SVC on the opposite side of the chest from the first SVC. In these scenarios, venography of the first SVC would be reported with 75827, and catheter placement and venography of the persistent/anomalous SVC would be reported with 93584.

#✚●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 (List separately in addition to code for primary procedure)

New code 93585 describes venography of the azygous/hemiazygous venous system.

#✚●93585 Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; azygos/hemiazygos venous system (List separately in addition to code for primary procedure)

Code 93586 is reported for venography of the coronary sinus.

#✚●93586 Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; coronary sinus (List separately in addition to code for primary procedure)

Codes 93587 and 93588 describe venography performed in venovenous collaterals originating either above or below the heart.

#✚●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) (List separately in addition to code for primary procedure)

#✚●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) (List separately in addition to code for primary procedure)

All five of these new CPT codes are reported in conjunction with the primary congenital cardiac catheterization code and are reported once per session.

Hyperthermic Intraperitoneal Chemotherapy (HIPEC)

Two new CPT codes are established to describe intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC). HIPEC is a procedure that involves intraoperative perfusion of a heated chemotherapy agent into the abdominal cavity through catheters.

HIPEC is distinct from, and performed in conjunction with, a separate primary procedure. It may include chemotherapy agent selection, confirmation of perfusion equipment settings for chemotherapy agent delivery, additional incision(s) for catheter and temperature probe placement, perfusion supervision and manual agitation of the heated chemotherapy agent in the abdominal cavity during chemotherapy agent dwell time, irrigation of the chemotherapy agent, closure of wounds related to HIPEC, and documentation of the chemotherapy agent and HIPEC procedure in the medical record.

This has previously been reported with unlisted CPT 96549 (Unlisted chemotherapy procedure.

New CPT 96547 is reported for the first 60 minutes of HIPEC and 96548 is reported for each additional 30 minutes. A parenthetical guideline under CPT 96548 lists the primary procedures which these codes are reportable with.

✚●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 each additional 30 minutes (List separately in addition to code for primary procedure)

►(Use 96547, 96548 in conjunction with 38100, 38101, 38102, 38120, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 44010, 44015, 44110, 44111, 44120, 44121, 44125, 44130, 44139, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44202, 44203, 44204, 44207, 44213, 44227, 47001, 47100, 48140, 48145, 48152, 48155, 49000, 49010, 49203, 49204, 49205, 49320, 58200, 58210, 58575, 58940, 58943, 58950, 58951, 58952, 58953, 58954, 58956, 58957, 58958, 58960)◄

Existing CPT 96446 for chemotherapy administration into the peritoneal cavity is editorially revised to indicate that the chemotherapy is administered via an implanted port or catheter.

A new parenthetical reference points to new codes 96547 and 96548 for reporting HIPEC.

▲96446 Chemotherapy administration into the peritoneal cavity via ~~indwelling~~ implanted port or catheter

►(For intraoperative hyperthermic intraperitoneal chemotherapy [HIPEC], see 96547, 96548)◄

Laser Treatment for Skin Disease

Existing CPTs 96920-96922 were identified in a high-volume growth screen. Utilization for these codes has been steadily increasing. The AMA believes that the growth is appropriate due to changes in treatment and medication for psoriasis, however the codes were referred to the CPT Editorial Panel for review/revision.

The Panel approved an editorial revision to include the term “excimer” in the descriptors to align them with their intended use.

Excimer laser devices emit UVB light, which is known to have therapeutic effects for certain skin conditions.

▲96920	Excimer ~~L~~laser treatment for ~~inflammatory skin disease (~~psoriasis~~)~~; total area less than 250 sq cm
▲96921	250 sq cm to 500 sq cm
▲96922	over 500 sq cm

Postoperative Low Level Laser Therapy

New CPT 97037 is established for reporting low-level laser therapy for postoperative pain reduction.

#●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 97037 in conjunction with 0552T)◄

►(For dynamic thermokinetic energies therapy, infrared, use 97026)◄

In the 2024 Medicare Physician Fee Schedule (PFS) final rule, CMS states that they were unaware that this code would be added to the 2024 CPT code set until after the publication of the proposed rule. They did not receive comments related to this code, and the AMA RUC committee did not provide a recommendation for valuation.

CMS has assigned this CPT non-covered status under the PFS final rule, referencing NCD 270.6 which states: "The use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy, is non-covered for the treatment, including the symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues."

Caregiver Training Services

Three new codes are established for reporting caregiver training services which are provided without the patient present.

Caregiver training is defined as direct, skilled intervention to provide strategies and techniques to equip caregiver(s) with knowledge and skills to assist patients living with functional deficits.

Codes 97550 and 97551 are used to report the total duration of face-to-face time spent by the qualified health care professional providing training to the caregiver(s) of an individual patient without the patient present.

●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)

Code 97552 is used to report group caregiver training provided to multiple sets of caregivers for multiple patients with similar conditions or therapeutic needs, without the patients present.

●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

During a skilled intervention, caregivers are trained using verbal instructions, video and live demonstrations, and feedback from the qualified health care professional on the use of strategies and techniques to facilitate functional performance and safety in the home or community setting.

Skilled training supports a caregiver's understanding of the patient's treatment plan, ability to engage in activities with the patient in between treatment sessions, and knowledge of external resources to assist in areas such as activities of daily living (ADLs), transfers, mobility, safety practices, problem solving, and communication.

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

Under the OPPS, CMS has elected to adopt these codes as recognized for partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs). CMS will include the costs associated with providing these services when calculating the PHP and IOP payment rates, but they will not count toward payment for a 3-service or 4-service day.

In the 2024 Medicare Physician Fee Schedule (PFS) final rule, CMS notes that they have historically taken the position that codes describing services furnished to other individuals without the patient's presence are not covered services. However, in certain circumstances, caregivers can play a key role in developing and carrying out the treatment plan established for the patient by the treating practitioner.

In this context, CMS believes that Caregiver Training Services (CTS) could be reasonable and necessary to treat the patient's illness or injury, as required by the Social Security Act. As such, CMS has made these codes payable under the PFS. See the 2024 PFS final rule for a detailed discussion regarding these new codes.

Category II Codes

Category II CPT Codes are a set of supplemental tracking codes which can be used for performance measurement.

These codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care.

The codes are alphanumeric and end in the letter "F" (e.g., 0001F). They are broken into the following categories:

Composite Measures	0001F-0015F
Patient Management	0500F-0584F
Patient History	1000F-1505F
Physical Examination	2000F-2060F
Diagnostic/Screening Processes or Results	3006F-3776F
Therapeutic, Preventive or Other Interventions	4000F-4563F
Follow-up or Other Outcomes	5005F-5250F
Patient Safety	6005F-6150F
Structural Measures	7010F-7025F
Non-Measure Claims Based Reporting	9001F-9007F

There are no changes to the Category II code set for 2024.

Category III Codes

Category III CPT codes are temporary codes that allow for data collection for emerging technologies, services, and procedures.

The inclusion of a service or procedure as a Category III CPT code does not constitute a finding of support, or lack thereof, regarding clinical efficacy, safety, applicability to clinical practice or payer coverage.

Category III codes may not always conform to the usual requirements for Category I CPT codes, including FDA approval, performance by many providers, consistency with medical practice or documented clinical efficacy.

For these reasons, some Category III CPT codes may not be covered by Medicare or other payers and may be considered experimental or investigational. Check with individual payers for coverage status.

It is important to review new Category III codes. If a procedure or service being performed has a Category III code established, this code must be reported rather than an unlisted code.

Category III codes are generally maintained for a period of five years. At the conclusion of this period (the "sunset date") they may be granted a permanent Category I CPT code. If not, the procedure or service would then be reported using an unlisted code.

For 2024, there are 82 new codes, 13 revised codes, and 32 deleted codes.

Of the 32 deleted codes, 23 of them have been converted to permanent Category I codes. These were discussed in the new codes' respective Category I sections throughout this manual. Remaining new, revised, and deleted codes will be discussed in the following pages.

New Category III Codes Effective in 2023

Category III CPT codes are introduced semiannually as they are approved by the CPT Editorial Panel. New codes are released by the AMA each January and July. The full set of codes is published annually in each CPT publication.

A number of codes are available for use prior to being published in the CPT manual due to the early release schedule.

At the September 2022 CPT Editorial Panel Meeting, 20 new codes were established for the 2024 CPT production cycle. Due to the early release schedule, these codes have been effective since 7/1/23. They are published for the first time in the CPT 2024 manual and are shown in the table below.

CPT	Change Status	SI '24	2024 Long Description
0791T	New	A	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)
0792T	New	E1	Application of silver diamine fluoride 38%, by a physician or other qualified health care professional
0793T	New	J1	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance
0794T	New	S	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
0795T	New	J1	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	New	J1	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; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)
0797T	New	J1	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; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)
0798T	New	J1	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)

CPT	Change Status	SI '24	2024 Long Description
0799T	New	J1	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right atrial pacemaker component
0800T	New	J1	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)
0801T	New	J1	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	New	J1	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; right atrial pacemaker component
0803T	New	J1	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; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)
0804T	New	Q1	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
0805T	New	C	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach
0806T	New	C	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach
0807T	New	S	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	New	S	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; 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
0809T	New*	D	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, placement of transfixing device(s) and intra-articular implant(s), including allograft or synthetic device(s)
0810T	New	T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies

*CPT 0809T was established effective July 1, 2023, but was subsequently deleted effective January 1, 2024. CPT guidance points to Category I codes 27278 and 27279 for this procedure.

All remaining Category III changes which are effective January 1, 2024 are discussed in the following sections.

Deleted Category III Codes with No Replacements

The following Category III CPT codes have reached their sunset dates and have not been granted permanent Category I CPT codes. As such, each will be reported with unlisted CPT codes if performed beginning in 2024.

See the table accompanying this manual for a crosswalk to the appropriate unlisted codes.

~~0508T~~ ~~Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia~~

~~0533T~~ ~~Continuous recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor for 6 days up to 10 days; includes set-up, patient training, configuration of monitor, data upload, analysis and initial report configuration, download review, interpretation and report~~

~~0534T~~ ~~set-up, patient training, configuration of monitor~~

~~0535T~~ ~~data upload, analysis and initial report configuration~~

~~0536T~~ ~~download review, interpretation and report~~

Noncontact Near-Infrared (NIR) Spectroscopy

Existing Category III CPT 0640T for spectroscopy studies of a flap or wound is revised for 2024 to instead describe spectroscopy studies performed at any anatomic site, other than for peripheral arterial disease (PAD) screening. Rather than being reported for each flap or wound, the code is reported for the first anatomic site studied.

New Category III code 0859T is established as an add-on code for reporting each additional anatomic site.

#▲0640T Noncontact near-infrared spectroscopy ~~studies of flap or wound~~ (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, ~~[StO2]),~~ image acquisition, interpretation, and report; ~~image acquisition, interpretation and report, each flap or wound~~ first anatomic site

#✚●0859T each additional anatomic site (List separately in addition to code for primary procedure)

Existing codes 0641T and 0642T which were previously used to report image acquisition only, or interpretation and report only, are deleted for 2024. These services are included in revised code 0640T.

~~0641T~~ ~~Noncontact near-infrared spectroscopy studies of flap or wound (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation [StO2]); image acquisition only, each flap or wound~~

~~0642T~~ ~~Noncontact near-infrared spectroscopy studies of flap or wound (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation [StO2]); interpretation and report only, each flap or wound~~

New code 0860T is established for NIR spectroscopy performed for screening for peripheral arterial disease (PAD).

#●0860T Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation, and report, one or both lower extremities

Wireless Cardiac Stimulation System for Left Ventricular Pacing

The existing family of Category III CPT codes for wireless cardiac stimulation systems for left ventricular pacing is revised, including the addition of three new codes, to allow for more granular reporting of stimulator pulse generator components.

A wireless left ventricular pacing system consists of a wireless endocardial left ventricle electrode and a pulse generator. The pulse generator has two components: a transmitter and a battery.

The electrode is typically implanted transarterially into the left ventricular wall and powered wirelessly using ultrasound delivered by a subcutaneously implanted transmitter. Two subcutaneous pockets are created on the chest wall, one for the battery and one for the transmitter, and these two components are connected by a subcutaneously tunneled cable.

Existing CPT 0517T currently describes insertion of pulse generator components; either the battery, transmitter, or both. This is revised for 2024 to specifically describe insertion of both components of the pulse generator.

▲0517T Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; ~~pulse generator~~ both component~~(s)~~ of pulse generator (battery and~~/or~~ transmitter) only

New code 0861T is established for removal of both pulse stimulator components and existing code 0518T is revised to describe removal of the battery component only.

#●0861T Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)

▲0518T Removal of ~~only~~ pulse generator ~~component(s) (battery and/or transmitter) of~~ for wireless cardiac stimulator for left ventricular pacing; battery component only

New codes 0862T and 0863T are established for reporting relocation of pulse generator components, either the battery (0862T) or the transmitter (0863T).

#●0862T Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only

#●0863T Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only

Finally, existing CPT codes 0519T and 0520T are revised to describe removal and replacement of either both pulse stimulator components (battery and transmitter, 0519T), or the battery component only (0520T). These codes are also revised to specify that device interrogation and programming is included in removal/ replacement procedures.

CPT 0520T previously included placement of a new electrode. According to new introductory guidance in the CPT manual, the electrode component of the stimulator is typically not removed once implanted.

▲0519T Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; ~~pulse generator~~ both component~~(s)~~ (battery and~~/or~~ transmitter)

▲0520T Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; ~~pulse generator~~ battery component~~(s)~~ only ~~(battery and/or transmitter), including placement of a new electrode~~

Tibial Integrated Neurostimulators

Existing Category III CPT codes 0587T-0590T were established in 2020 for reporting procedures related to posterior tibial nerve integrated (single device) neurostimulation systems.

These codes are revised for 2024 to indicate use for the treatment of bladder dysfunction. This change coincides with the establishment of three new codes to describe peripheral nerve integrated neurostimulation systems (discussed on page **35**), which are not relevant to patients with bladder dysfunction. This is an editorial revision that does not change the codes' intended use.

CPT 0588T for revision or removal is also revised to specify revision or removal of a percutaneously placed integrated neurostimulator. This is to differentiate the code from new codes for open posterior tibial nerve neurostimulator procedures, discussed on the next page.

▲0587T Percutaneous implantation or replacement of integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve

▲0588T Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve

▲0589T Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (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, posterior tibial nerve, 1-3 parameters

▲0590T Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (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, posterior tibial nerve, 4 or more parameters

Four new Category III CPT codes shown below are established for 2024 to report integrated posterior tibial nerve neurostimulators that are inserted, replaced, revised, or removed via an open approach.

Code selection is dependent on whether the device is placed subcutaneously or subfascial.

●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

Lumbar or Thoracolumbar Vertebral Body Tethering

Existing Category III CPT codes 0656T and 0657T for anterior vertebral body tethering are revised to specify lumbar or thoracolumbar procedures.

This is due to the establishment of new permanent Category I CPT codes specific to anterior thoracic vertebral body tethering, as discussed on page **22** of this manual.

New parenthetical guidelines point to the Category I CPT codes when performed on the thoracic spine.

▲0656T Anterior lumbar or thoracolumbar ~~V~~vertebral body tethering~~, anterior~~; up to 7 vertebral segments

▲0657T 8 or more vertebral segments

►(For vertebral body tethering of the thoracic spine, see 22836, 22837)◄

New CPT 0790T has been established for reporting the revision, replacement, or removal of lumbar or thoracolumbar vertebral body tethering. Previously no CPT existed to describe this service, which would be reported with an unlisted code.

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

►(For revision, replacement, or removal of thoracic vertebral body tethering, use 22838)◄

Digital Pathology

In the 2023 CPT code set, 13 new Category III CPT codes were established for reporting the additional clinical staff work and service requirements associated with digitizing glass microscope slides for primary diagnosis.

Glass microscope slides are scanned by clinical staff and whole-slide images (either in real-time or stored in a computer server or cloud-based digital image archival and communication system) are used for digital examination for pathologic diagnosis distinct from direct visualization through a microscope.

This allows for remote examination by the pathologist and/or in conjunction with the use of artificial intelligence (AI) algorithms.

The CPT codes should not be reported for digitization that is solely for archival purposes, educational purposes, for developing a database for training or validation of AI algorithms, or for clinical conference presentations (i.e., the service must be performed for individual patient reporting).

The thirteen codes established for 2023 described digitization of stains related to surgical pathology, special stains, and immunohistochemical/immunocytochemical stains.

Each Category III add-on code is reported as a one-to-one unit of service for each primary pathology service code, as referenced in the parenthetical guideline beneath each code.

For 2024, thirty additional codes are established for reporting the digitization of other slides such as cytopathology, referred slides, frozen sections, archived slides, immunofluorescence, in situ hybridization, blood smears, and electron microscopy.

#✚●0827T Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; smears with interpretation (List separately in addition to code for primary procedure)

►(Use 0827T in conjunction with 88104)◄

#✚●0828T Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; simple filter method with interpretation (List separately in addition to code for primary procedure)

►(Use 0828T in conjunction with 88106)◄

#✚●0829T Digitization of glass microscope slides for cytopathology, concentration technique, smears, and interpretation (eg, Saccomanno technique) (List separately in addition to code for primary procedure)

►(Use 0829T in conjunction with 88108)◄

#✚●0830T Digitization of glass microscope slides for cytopathology, selective-cellular enhancement technique with interpretation (eg, liquid-based slide preparation method), except cervical or vaginal (List separately in addition to code for primary procedure)

►(Use 0830T in conjunction with 88112)◄

#✚●0831T Digitization of glass microscope slides for cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician (List separately in addition to code for primary procedure)

►(Use 0831T in conjunction with 88141)◄

#✚●0832T Digitization of glass microscope slides for cytopathology, smears, any other source; screening and interpretation (List separately in addition to code for primary procedure)

►(Use 0832T in conjunction with 88160)◄

#✚●0833T Digitization of glass microscope slides for cytopathology, smears, any other source; preparation, screening and interpretation (List separately in addition to code for primary procedure)

►(Use 0833T in conjunction with 88161)◄

#✚●0834T Digitization of glass microscope slides for cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains (List separately in addition to code for primary procedure)

►(Use 0834T in conjunction with 88162)◄

#✚●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 (List separately in addition to code for primary procedure)

►(Use 0835T in conjunction with 88172)◄

►(Do not report 0835T in conjunction with 88172, when 0837T is reported in conjunction with 88173)◄

#✚●0836T Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)

►(Use 0836T in conjunction with 88177)◄

►(Do not report 0836T in conjunction with 88177, when 0837T is reported in conjunction with 88173)◄

#✚●0837T Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; interpretation and report (List separately in addition to code for primary procedure)

►(Use 0837T in conjunction with 88173)◄

#✚●0838T Digitization of glass microscope slides for consultation and report on referred slides prepared elsewhere (List separately in addition to code for primary procedure)

►(Use 0838T in conjunction with 88321)◄

#✚●0839T Digitization of glass microscope slides for consultation and report on referred material requiring preparation of slides (List separately in addition to code for primary procedure)

►(Use 0839T in conjunction with 88323)◄

►(Do not report 0839T in conjunction with 88323 for referred digitized glass microscope slides prepared elsewhere)◄

#✚●0840T Digitization of glass microscope slides for consultation, comprehensive, with review of records and specimens, with report on referred material (List separately in addition to code for primary procedure)

►(Use 0840T in conjunction with 88325)◄

►(Do not report 0840T in conjunction with 88325 for referred digitized glass microscope slides prepared elsewhere)◄

#✚●0841T Digitization of glass microscope slides for pathology consultation during surgery; first tissue block, with frozen section(s), single specimen (List separately in addition to code for primary procedure)

►(Use 0841T in conjunction with 88331)◄

#✚●0842T Digitization of glass microscope slides for pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)

►(Use 0842T in conjunction with 88332)◄

#✚●0843T Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg, touch preparation, squash preparation), initial site (List separately in addition to code for primary procedure)

►(Use 0843T in conjunction with 88333)◄

#✚●0844T Digitization of glass microscope slides for pathology consultation during surgery; cytologic examination (eg, touch preparation, squash preparation), each additional site (List separately in addition to code for primary procedure)

►(Use 0844T in conjunction with 88334)◄

#✚●0845T Digitization of glass microscope slides for immunofluorescence, per specimen; initial single antibody stain procedure (List separately in addition to code for primary procedure)

►(Use 0845T in conjunction with 88346)◄

#✚●0846T Digitization of glass microscope slides for immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)

►(Use 0846T in conjunction with 88350)◄

#✚●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) (List separately in addition to code for primary procedure)

►(Use 0847T in conjunction with 88363)◄

►(Do not report 0847T in conjunction 88363, when digitization of glass microscope slides has been previously reported)◄

#✚●0848T Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)

►(Use 0848T in conjunction with 88365)◄

#✚●0849T Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)

►(Use 0849T in conjunction with 88364)◄

#✚●0850T Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)

►(Use 0850T in conjunction with 88366)◄

#✚●0851T Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; initial single probe stain procedure (List separately in addition to code for primary procedure)

►(Use 0851T in conjunction with 88368)◄

#✚●0852T Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)

►(Use 0852T in conjunction with 88369)◄

#✚●0853T Digitization of glass microscope slides for morphometric analysis, in situ hybridization (quantitative or semiquantitative), manual, per specimen; each multiplex probe stain procedure (List separately in addition to code for primary procedure)

►(Use 0853T in conjunction with 88377)◄

#✚●0854T Digitization of glass microscope slides for blood smear, peripheral, interpretation by physician with written report (List separately in addition to code for primary procedure)

►(Use 0854T in conjunction with 85060)◄

►(Do not report 0854T in conjunction with 85060, when digitization of glass microscope slides is performed using an automated, computer-assisted cell-morphology imaging analyzer)◄

#✚●0855T Digitization of glass microscope slides for bone marrow, smear interpretation (List separately in addition to code for primary procedure)

►(Use 0855T in conjunction with 85097)◄

#✚●0856T Digitization of glass microscope slides for electron microscopy, diagnostic (List separately in addition to code for primary procedure)

►(Use 0856T in conjunction with 88348)◄

Additional clarifying guidelines have been added to the introductory section for Digital Pathology Digitization procedures stating that static digital photographic and photomicrographic imaging or digital video streaming of any portion of a glass microscope slide on mobile smartphone and tablet devices does not constitute a digital pathology digitization procedure.

Peripheral Nerve Transcutaneous Magnetic Stimulation

Category III CPT codes for peripheral nerve transcutaneous magnetic stimulation are revised to no longer differentiate between initial and subsequent treatments.

Codes 0766T and 0767T, which previously described initial treatment, now refer only to the first and each additional nerve treated.

▲0766T Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, ~~initial treatment,~~ with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve

✚▲0767T each additional nerve (List separately in addition to code for primary procedure)

Codes 0768T and 0769T for subsequent treatment are deleted. Codes 0766T and 0767T are now used regardless of initial or subsequent treatment.

~~0768T~~ ~~Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve~~

~~0769T~~ ~~Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)~~

►(0768T, 0769T have been deleted)◄

►(For transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, see 0766T, 0767T)◄

Revised coding guidelines explain that the selected nerve is mapped and localized using magnetic stimulation at the time of each treatment and the appropriate amplitude of magnetic stimulation is defined. There is no need to differentiate between initial and subsequent treatments.

Spinal and Sacral Integrated Neurostimulators

Six new Category III CPT codes are established for reporting spinal or sacral integrated neurostimulator services.

A neurostimulator system includes an implanted pulse generator or receiver which delivers electrical stimulation via an electrode array. The pulse generator or receiver may be integrated with the electrode array (single-component implant) or have a detachable connection to the electrode array (two or more component implant).

Like new Category I codes for peripheral integrated neurostimulators (discussed on page **35**), and existing Category III codes for tibial integrated neurostimulators (discussed on page **81**), new codes 0784T-0787T describe spinal or sacral integrated neurostimulator insertion, replacement, revision, or removal.

●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

New codes 0788T and 0789T are used to report electronic analysis and programming of the integrated neurostimulation system.

Code 0788T describes simple programming, which is defined as 1-3 parameters.

●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

Code 0789T describes complex programming, which is defined as 4 or more parameters.

●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

Remote Multi-Day Complex Uroflowmetry

New Category III codes 0811T and 0812T are established for reporting remote multi-day complex uroflowmetry.

This procedure involves remote monitoring of uroflowmetry performed at a patient's home using a personal uroflowmeter that wirelessly connects to a mobile app and measures a patient's voiding activities. The data is sent back to the physician's office in a comprehensive clinical report to show the flow study results.

Code 0811T is used to report the initial set-up and patient education on use of the equipment.

Code 0812T is reported for the device supply and automated report generation.

●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

►(Do not report 0811T, 0812T more than once per episode of care)◄

►(Do not report 0811T, 0812T in conjunction with 51736, 51741, 99453, 99454)◄

These codes may not be reported in conjunction with existing CPT codes 51736 or 51741 for uroflowmetry.

These codes also may not be reported in conjunction with CPTs 99453-99453 for remote physiologic monitoring.

Adjustment of Gastric Balloon

Category III CPT 0813T is established to report endoscopic volume adjustment of an intragastric bariatric balloon.

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

►(Do not report 0813T in conjunction with 43197, 43198, 43235, 43241, 43247, 43290, 43291)◄

Category I CPT codes 43290 and 43291 were established effective January 1, 2023 to describe deployment and removal of intragastric bariatric balloons.

This weight loss procedure involves the insertion of a deflated balloon through the esophagus and into the stomach which is then filled with a sterile saline solution.

New code 0813T describes subsequent volume adjustment of a previously placed intragastric balloon. It should not be reported in conjunction with the initial placement procedure, or other endoscopy codes that are inherent to the volume adjustment.

Insertion of Calcium-Based Implant - Femur

New Category III CPT 0814T is used to report the percutaneous injection of calcium-based biodegradable osteoconductive material in the femur.

This therapeutic procedure is used for fracture stabilization in high-risk patients where more invasive surgical approaches may be contraindicated.

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

►(Do not report 0814T in conjunction with 26992, 77002)◄

The CPT is inclusive of imaging guidance, which is not separately reportable.

Ultrasound-Based REMS Axial Bone Density Study

New CPT 0815T is established for reporting bone density and fracture risk assessment using ultrasound-based radiofrequency multi-spectrometry (REMS).

●0815T Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine

Currently, dual-energy X-ray absorptiometry (DXA) is the most commonly used method for assessing bone mineral density (BMD).

REMS is a non-ionizing technology that evaluates the bone status at axial skeletal sites by analyzing raw ultrasound signals. The new technology does not use radiation, making it a potential method of choice for the assessment of bone status in children and in women of childbearing age or who are pregnant. Clinical studies have found diagnostic parity between BMD performed using REMS compared to DXA.

Psychedelic Drug Monitoring Services

Three new Category III CPT codes are established for reporting psychedelic drug monitoring services. Continuous in-person monitoring and intervention (e.g., psychotherapy, crisis intervention) is provided during and following supervised patient self-administration of a psychedelic medication in a therapeutic setting.

The medications' pharmacologic risks may persist for multiple hours during which the patient may require continuous in-person monitoring and intervention by a physician/QHP to support the patient's physical, emotional, and psychological safety and to optimize treatment outcomes.

Code 0820T is used to report the total in-person time of the physician/QHP providing continuous monitoring, and intervention as needed, during psychedelic medication therapy.

●0820T Continuous 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

►(Do not report 0820T in conjunction with 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 96116, 96121, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 99415, 99416, on the same date of service)◄

Codes 0821T and 0822T are used to report the concurrent in-person participation of a second physician/QHP (0821T), or clinical staff (0822T) based on a patient's complex presentation that requires additional personnel in the room (e.g., a physician/QHP needs assistance from additional clinical staff due to a crisis by the psychedelic experience that surfaces past psychological trauma).

✚●0821T second 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)

✚●0822T clinical 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)

Psychotherapy (90832-90838), psychotherapy for crisis (90839-90840), neurobehavioral status examination (96116, 96121), adaptive behavior assessments (97151-97152), adaptive behavior treatment (97153-97158), or prolonged clinical staff services (99415-99416) may not be reported on the same date of service.

Right Atrial Leadless Pacemaker

A series of four new Category III CPT codes is established for reporting right atrial leadless pacemaker procedures.

A right atrial single-chamber leadless pacemaker includes a pulse generator with a built-in battery and electrode for implantation into the right atrium. Implantation of the atrial leadless pacemaker is performed using a catheter under fluoroscopic guidance via transvenous access.

New codes 0823T-0826T apply to single-chamber leadless pacemakers implanted in the right atrium, intended for atrial pacing only, and that are not part of a dual-chamber leadless system.

Report transcatheter insertion of the right atrial single-chamber leadless pacemaker with CPT 0823T. Code 0824T describes transcatheter removal, and code 0825T describes removal and replacement.

●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

Fluoroscopy (76000, 77002), ultrasound guidance for vascular access (76937), right ventriculography (93566), and femoral venography (75820) are included when performed, and are not separately reportable.

According to the AMA, leadless pacemakers are modular systems, and a dual-chamber leadless pacemaker may be implanted in stages with one pacemaker implanted into the right ventricle at the initial procedure and one pacemaker implanted into the right atrium at a subsequent session.

When a right atrial leadless pacemaker component of a dual-chamber system is modified or a right atrial leadless pacemaker is implanted to complete a dual-chamber leadless pacemaker system, see existing Category III codes 0796T, 0799T, or 0802T, which were established effective July 1, 2023 for dual chamber leadless pacemakers.

Programming device evaluation (in person) of a right atrial single-chamber leadless pacemaker is reported with new CPT 0826T. Device evaluation code 93279 may not be reported in conjunction with right atrial single-chamber leadless pacemaker system codes.

●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

Opto-Acoustic Imaging for Breast Masses

New code 0857T is established to report opto-acoustic breast imaging.

HCPCS C9788 had previously been established by CMS effective October 1, 2023 to report this service, resulting from a new technology application received for the Imagio® Breast Imaging System. HCPCS C9788 is deleted for 2024 (discussed on page **114**) due to the establishment of this Category III CPT.

✚●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)

►(Use 0857T in conjunction with 76641, 76642)◄

Opto-acoustic imaging combines anatomic and functional diagnostic imaging through the use of light (laser optics) and sound (conventional ultrasound) to produce high-contrast images.

CPT 0857T is an add-on code reported in conjunction with CPT 76641 or 76642 for breast ultrasound.

Transcranial Magnetic Stimulation (TMS)

CPT 0858T is established for reporting measurement of evoked cortical potentials associated with transcranial magnetic stimulation of two or more cortical areas using multiple, externally applied scalp electrode channels. This non-invasive technique is used to study the physiology of the human brain.

●0858T Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report

►(Do not report 0858T in conjunction with 95836, 95957, 95961, 95965, 95966)◄

Upon stimulation, the device performs automated signal processing indicating brain physiological features of connectivity, excitability, and plasticity, which may be impaired with structural and functional brain deficits. Because these physiological features may be altered in certain types of brain disease, the device's automated report of analyzed data is intended to provide clinical insight of brain function within the context of certain brain disease states.

Low Intensity ESWT-Corpus Cavernosum

New Category III CPT 0864T describes low-intensity extracorporeal shock wave therapy of the corpus cavernosum.

This procedure may be performed for the treatment of erectile dysfunction (ED).

●0864T Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy

►(Do not report 0864T in conjunction with 0101T when treating the same area)◄

This new CPT should not be reported in conjunction with existing CPT 0101T "Extracorporeal shock wave involving musculoskeletal system, not otherwise specified" when treating the same area.

Quantitative MRI Analysis of Brain

New CPT codes 0865T and 0866T are established for reporting quantitative MRI analysis of the brain.

The codes were requested by Icometrix regarding their FDA-cleared, AI-related brain MRI quantification software.

The quantitative insights assist clinicians to diagnose, monitor, and assess treatment response for brain disorders such as multiple sclerosis, Alzheimer's Disease and Dementia, Epilepsy, Traumatic Brain Injury, Stroke, etc.

CPT 0865T is reported when the quantitative analysis is obtained without a diagnostic MRI exam during the same session.

CPT 0866T is an add-on code reported in conjunction with an MRI exam when both are performed during the same session.

●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

►(Do not report 0865T in conjunction with 70551, 70552, 70553)◄

✚●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)

►(Use 0866T in conjunction with 70551, 70552, 70553)◄

►(For quantitative MR for analysis of tissue composition, see 0648T, 0649T, 0697T, 0698T)◄

►(For quantitative computed tomography tissue characterization, see 0721T, 0722T)◄

►(For quantitative MRI analysis of the brain without comparison to prior MR study, report 0865T, 0866T with modifier 52)◄

Part II: Key Changes in HCPCS for 2024

Transportation, Med/Surg Supplies, Misc & Experimental – "A" Codes

- 75 new codes
- Seven revised codes

Medical/Surgical Supplies

There are 73 new and seven revised HCPCS A-codes for medical supplies in the 2024 HCPCS code set.

Most of the new and revised codes are for DME supplies, including many new codes for gradient compression stockings for lymphedema compression treatment.

See the table that accompanies this manual for the complete listing.

Diagnostic Radiopharmaceuticals

New HCPCS A9608 is established for reporting diagnostic flotufolastat F18 (brand name POSLUMA®). This is a separately payable pass-through radiopharmaceutical (status indicator "G") under the OPPS. This permanent HCPCS A-code is replacing temporary HCPCS C-code, C9156, which is deleted for 2024.

●A9608 Flotufolastat f 18, diagnostic, 1 millicurie

New HCPCS A9609 describes fludeoxyglucose F18 (FDG). This code will be packaged (status indicator "N") under the OPPS. This new code was requested by RefleXion Medical Inc. to use for FDG-guided treatment, such as their SCINTIX™ therapy.

●A9609 Fludeoxyglucose f18 up to 15 millicuries

Temporary Hospital OPPS – "C" Codes

- 21 new codes
- 11 deleted codes

HCPCS C-codes are temporary codes that are established to report drugs, biologicals, procedures, and devices which must be used by OPPS hospitals. These codes may also be recognized on claims from other providers and other payment systems.

Pass-Through Medical Devices

Five new HCPCS codes are established for reporting devices that have been granted pass-through payment status under the OPPS effective January 1, 2024.

HCPCS C1600 describes the FLEX Vessel Prep™ System, manufactured by Venture Med Group, Inc. This product is an endovascular, over-the-wire, retractable, sheathed catheter with a three-strut treatment element at the distal tip used to help resolve stenoses occluding vascular access in patients with End-Stage Renal Disease (ESRD) on hemodialysis.

●C1600 Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)

HCPCS C1601 describes Ambu® aScope™ 5 Broncho HD, manufactured by Ambu Inc. This product is an imaging/illumination bronchoscope device that uses an integrated camera module and built-in dual LED illumination to provide access to, and imaging of, the lungs for diagnostic and therapeutic purposes for patients with pulmonary pathology.

●C1601 Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)

HCPCS C1602 describes CERAMENT® G, manufactured by BONESUPPORT AB. This product is an implantable bone void filler combination device/drug that remodels into bone and elutes gentamicin.

●C1602 Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)

HCPCS C1603 describes the CavaClear Inferior Vena Cava (IVC) Filter Removal Laser Sheath, manufactured by Phillips North America, LLC. This device is used for tissue ablation in the removal of embedded IVC filters that have failed a previous retrieval method.

●C1603 Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)

HCPCS C1604 is effective January 1, 2024 and describes a transmural transvenous arterial bypass graft with delivery system. This HCPCS was not addressed in the 2024 OPPS Final Rule and no guidance has been published by CMS regarding this code at the time of the publication of this manual.

●C1604 Graft, transmural transvenous arterial bypass (implantable), with all delivery system components

Complexity-Adjusted Services for ASC Payment System

Beginning in CY 2023, CMS established HCPCS C-codes that describe complexity-adjusted services for use under the ambulatory surgical center (ASC) payment system.

The purpose of the codes is to allow for higher payment rates to be assigned under the ASC payment system for combinations of primary procedures and add-on codes which would qualify for complexity adjustments under the OPPS.

Comprehensive APC payment methodology cannot be adopted in the ASC payment system due to limitations of the ASC claims processing systems. As such, claims containing procedures assigned to comprehensive APCs under the OPPS are treated the same as other claims that contain separately payable procedure codes under the ASC payment system.

In the ASC payment system, when multiple procedures are performed together in a single operative session, most covered surgical procedures are subject to a 50-percent reduction for the lower-paying procedure. Add-on procedure codes are not separately payable under the ASC payment system and are always packaged into the ASC payment rate for the procedure.

CMS determined that this resulted in financial disincentives for providers to offer these services in the ASC setting.

Complexity adjusted C-codes represent service combinations that would result in additional payments via complexity adjustments under the OPPS. They are for ASC use only and are not reportable under the OPPS (assigned non-covered status indicator “E1” under the OPPS).

Four new complexity-adjusted C-codes are established for 2024, as shown in the table on the following page.

New ASC Complexity-Adjusted C-Codes for 2024

CPT / HCPCS	Long Description
C7556	Bronchoscopy, rigid or flexible, with bronchial alveolar lavage and transendoscopic endobronchial ultrasound (ebus) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s), including fluoroscopic guidance, when performed
C7557	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed and intraprocedural coronary fractional flow reserve (ffr) with 3d functional mapping of color-coded ffr values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention
C7558	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography with pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed
C7560	Endoscopic retrograde cholangiopancreatography (ercp) with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s) and endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s)
~~C7561~~	~~Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less with manual preparation and insertion of drug-delivery device(s), deep (e.g., subfascial)~~

***Note:** HCPCS C7561 was published in the initial 2024 HCPCS release, but CMS released an updated file on 12/4/2023 indicating that they have retracted the creation of this code, which will not be established for 2024.

Remote Group Psychotherapy

In the CY 2023 OPPS final rule CMS finalized the creation of three HCPCS C-codes to describe mental health services furnished by hospital staff to beneficiaries in their homes through communications technology, as shown in the table below.

HCPCS Code	Long Descriptor
C7900	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 15-29 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service
C7901	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 30-60 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service
C7902	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service (List separately in addition to code for primary service)

CMS did not specify whether they should be used for individual or group services, preferring to keep the coding more general until they gathered information about the use of these new codes.

However, commentors have expressed that when a beneficiary is receiving multiple units of group therapy a day, it is administratively burdensome to report and document each unit of time using multiple codes.

Instead, commentors requested that CMS create a single, untimed code that can be reported when a beneficiary receives multiple hours of group therapy per day.

As such, CMS has established new HCPCS C7903, shown below, which is used to report group psychotherapy furnished by hospital staff to patients in their homes.

●C7903	Group psychotherapy service for diagnosis, evaluation, or treatment of a mental health or substance use disorder provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service

Note: CMS also said in the CY 2024 OPPS final rule that they were removing the term "initial" from codes C7900 and C7901 to avoid confusion and revising C7902 to limit to billing with HCPCS C7901, however these changes were not shown in the initial or the second 2024 HCPCS release files. It is possible that a revised HCPCS release will be published with these additional changes.

Drugs and Biologicals

Seven temporary HCPCS C-codes for drugs and biologicals are deleted for 2024 and replaced with permanent HCPCS J- or A-codes, as shown in the table below.

Each of the replacement codes is an exact one-to-one replacement with the same billing units. Each code is approved for pass-through payment (status indicator "G") under the OPPS in 2024.

HCPCS	Description	Replacement
C9152	Injection, aripiprazole, (abilify asimtufii), 1 mg	J0402
C9153	Injection, amisulpride, 1 mg	J0184
C9154	Injection, buprenorphine extended-release (brixadi), 1 mg	J0576
C9155	Injection, epcoritamab-bysp, 0.16 mg	J9321
C9156	Flotufolastat f 18, diagnostic, 1 millicurie	A9608
C9157	Injection, tofersen, 1 mg	J1304
C9158	Injection, risperidone, (uzedy), 1 mg	J2799

Seven new temporary HCPCS C-codes are established effective January 1, 2024 for reporting drugs and biologicals. Each of these drugs is also approved for separate pass-through payment under the OPPS in 2024.

HCPCS	Description
C9159	Injection, prothrombin complex concentrate (human), balfaxar, per i.u. of factor ix activity
C9160	Injection, daxibotulinumtoxina-lanm, 1 unit
C9161	Injection, aflibercept hd, 1 mg
C9162	Injection, avacincaptad pegol, 0.1 mg
C9163	Injection, talquetamab-tgvs, 0.25 mg
C9164	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)
C9165	Injection, elranatamab-bcmm, 1 mg

New Technology Procedures

CMS regularly establishes HCPCS C-codes for new procedures resulting from new technology applications. The HCPCS C-codes allow for Medicare coverage of new procedures in the absence of CPT codes being established by the AMA.

If CPT codes are subsequently established by the AMA for the same procedure, CMS will delete the HCPCS C-code and accept the new CPT. Three HCPCS C-codes for such procedures are deleted for 2024 due to the establishment of CPT codes.

HCPCS C9770 describes the administration of subretinal medication requiring vitrectomy. This code is deleted for 2024 due to the establishment of Category III CPT 0810T by the AMA effective July 1, 2023, which describes the same procedure.

~~C9770~~ ~~Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent~~

HCPCS C9771 was established by CMS effective January 1, 2021 to report the first energy-based ablation technology FDA cleared for ablation of nasal tissue and/or nerves. As discussed on page **25**, the AMA has established new CPT 31243 effective January 1, 2024 which describes nasal/sinus endoscopy with posterior nasal nerve cryoablation.

~~C9771~~ ~~Nasal/sinus endoscopy, cryoablation nasal tissue(s) and/or nerve(s), unilateral or bilateral~~

HCPCS C9788 was established by CMS effective October 1, 2023 based on a new technology application received for the Imagio® Breast Imaging System. The AMA has established Category III CPT 0857T effective January 1, 2024, which describes this same service, as discussed on page **101**.

~~C9788~~ ~~Opto-acoustic imaging, breast (including axilla when performed), unilateral, with image documentation, analysis and report, obtained with ultrasound examination~~

Three new HCPCS C-codes are established for new technology procedures effective January 1, 2024.

HCPCS C9793 describes 3D predictive model generation for cardiac procedure planning using data from a cardiac CTA.

●C9793 3D predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report

HCPCS C9794 and C9795 describe simulation-aided field setting and stereotactic body radiation therapy delivery using PET imaging.

●C9794 Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)

●C9795 Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions

These new HCPCS were not addressed in the 2024 OPPS Final Rule and no guidance has been published by CMS regarding these codes at the time of the publication of this manual.

COVID-19 Specimen Collection

HCPCS C9803 was established during the COVID-19 public health emergency (PHE) to facilitate widespread testing for COVID-19.

CMS indicated at the time that this code was created that it was only intended to meet the need of the COVID–19 PHE and that they expected to retire this code at the conclusion of the PHE.

After consideration of public comments, CMS does not believe it is necessary for the code to remain active in CY 2024. The HCPCS will be deleted with no replacement.

~~C9803~~	~~Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source~~

CMS said in the CY 2024 OPPS final rule that they will continue to explore coding opportunities for nasopharyngeal swab specimen collection, where appropriate.

Durable Medical Equipment – "E" Codes

- 15 new codes

HCPCS E-codes describe durable medical equipment. Most E-codes are billable to a DME MAC only by licensed DME suppliers.

There are 15 new HCPCS describing DME items effective January 1, 2024, as shown in the table below.

HCPC	SI	Long Description
E0492	E1	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application
E0493	E1	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply
E0530	Y	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type
E0678	Y	Non-pneumatic sequential compression garment, full leg
E0679	Y	Non-pneumatic sequential compression garment, half leg
E0680	Y	Non-pneumatic compression controller with sequential calibrated gradient pressure
E0681	Y	Non-pneumatic compression controller without calibrated gradient pressure
E0682	Y	Non-pneumatic sequential compression garment, full arm
E0732	Y	Cranial electrotherapy stimulation (ces) system, any type
E0733	Y	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve
E0734	Y	External upper limb tremor stimulator of the peripheral nerves of the wrist
E0735	Y	Non-invasive vagus nerve stimulator
E1301	E1	Whirlpool tub, walk-in, portable
E2001	Y	Suction pump, home model, portable or stationary, electric, any type, for use with external urine management system
E3000	Y	Speech volume modulation system, any type, including all components and accessories

Temporary Procedures and Professional Services - "G" Codes

- 16 new codes
- 32 deleted codes
- 37 revised code descriptions

HCPCS G-codes are used to identify professional health care procedures and services that would otherwise be coded in CPT but for which there are no CPT codes available. They are established internally by CMS to support Medicare claims processing needs.

Physician Quality and Data Reporting Codes

The set of HCPCS G-codes includes numerous codes that are used for physician quality and data reporting, including for the merit-based incentive payment system (MIPS).

As is usual each year, a number of changes have been made to the physician quality and data reporting codes.

The table provided with this manual includes 31 deleted and 32 revised physician quality reporting codes (assigned statis indicator M "Items and Services Not Billable to the Fiscal Intermediary" under the OPPS).

Pre-exposure Prophylaxis (PrEP) to Prevent HIV Infection

The Social Security Act allows that CMS may cover "additional preventive services," if it determines through the national coverage determination (NCD) process that the service is recommended with a grade A (strongly recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and that it also meets certain other requirements.

On December 13, 2022 the USPSTF published a draft recommendation with a grade A for prescribing PrEP with effective antiretroviral therapy to people who are at increased risk of HIV acquisition to decrease the risk.

CMS initiated a national coverage analysis for PrEP on January 12, 2023.

On July 12, 2023 CMS released a proposed decision memo explaining that they determined that PrEP is reasonable and necessary for the prevention or early detection of illness or disability under the Act, and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B. This opened a 30-day public comment period.

CMS proposes coverage of PrEP using antiretroviral drugs (whether oral or injectable) approved by the FDA to prevent HIV infection in individuals at high risk of HIV acquisition. CMS also proposes to cover the administration of injectable PrEP using antiretroviral drugs to prevent HIV infection. PrEP involves the use of antiretroviral drugs on an ongoing basis or before and after HIV exposure. When taken as directed, PrEP is highly effective for preventing HIV. Further, CMS is also proposing to cover additional HIV screenings up to 7 times annually and a single screening for hepatitis B virus (HBV) for these high-risk patients.

PrEP medications are currently covered under Medicare Part D but may have cost-sharing and deductibles. Under the proposal, both oral and injectable forms of the medication would be covered for certain individuals under Part B as an “additional preventive service,” and without requiring payment of Part B coinsurance or deductible.

See the proposed decision memo here:
https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=310

On August 28, 2023 the USPSTF issued their final recommendation titled "Prevention of Acquisition of HIV: Preexposure Prophylaxis" in which they assigned it a grade A recommendation.

See the final USPSTF report here:
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis

On October 10, 2023, CMS advised that they were not yet releasing a National Coverage Determination for PrEP, but that a decision is forthcoming.

CMS has provided no further updates at the time of the publication of this manual. However, three new HCPCS G-codes have been established effective January 1, 2024, as shown below.

- G0011 Individual counseling for pre-exposure prophylaxis (PrEP) by physician or qualified health care professional (QHP)to prevent human immunodeficiency virus (HIV), includes HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence, 15-30 minutes
- G0012 Injection of pre-exposure prophylaxis (PrEP) drug for HIV prevention, under skin or into muscle
- G0013 Individual counseling for pre-exposure prophylaxis (PrEP) by clinical staff to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence

These codes are not included in either the OPPS or PFS final rules. More details from CMS are expected soon. See the National Coverage Analysis (NCA) tracking sheet on the CMS website to track further updates:

https://www.cms.gov/medicare-coverage-database/view/ncacal-tracking-sheet.aspx?NCAId=310

Psychotherapy for Crisis

Two new HCPCS G-codes, G0017 and G0018, are established effective January 1, 2024 to describe psychotherapy for crisis furnished in places of services where the non-facility rate applies under the Medicare Physician Fee Schedule, other than the office setting.

- G0017 Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes
- G0018 Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes (list separately in addition to code for primary service)

These codes are established resulting from section 4123(a)(1) of the CAA, 2023, Improving Mobile Crisis Care in Medicare, which requires the Secretary to establish new HCPCS codes under the PFS for psychotherapy for crisis services that are furnished in "an applicable site of service."

The payment amount for these codes must be equal to 150 percent of the fee schedule amount for non-facility sites of service for the services identified by CPT codes 90839 (Psychotherapy for crisis; first 60 minutes) and 90840 (each additional 30 minutes), and any succeeding codes.

An applicable site of service is defined as a site of service other than a site where the facility rate under the PFS applies and other than an office setting.

The facility rate applies to services furnished in a hospital, skilled nursing facility, community mental health center, hospice, ambulatory surgical center, wholly owned or wholly operated entity providing preadmission services under §412.2(c)(5), or for certain services furnished via telehealth.

The non-facility rate is paid in all other settings, including a physician's office, the patient's home, a nursing facility, or a comprehensive outpatient rehabilitation facility.

CMS defines the term “home” broadly to include temporary lodging, such as hotels and homeless shelters. In circumstances where the patient, for privacy or other personal reasons, chooses to travel a short distance from the exact home location to receive the service, that would qualify as the patient’s home.

CMS provides the full list of places of service on the CMS website at https://www.cms.gov/Medicare/Coding/place-of-service-codes.

Services Addressing Health-Related Social Needs

In recent years, CMS has sought to recognize significant changes in health care practice and has been engaged in an ongoing, incremental effort to identify gaps in appropriate coding and payment for care management/coordination and primary care services under the PFS (e.g., transitional care management, chronic care management, behavioral health care management) to improve payment accuracy and to better recognize resources involved in care management and coordination for certain patient populations

To continue to improve payment accuracy, CMS is exploring ways to better identify and value practitioners' work when they incur additional time and resources helping patients with serious illnesses to navigate the healthcare system or removing health-related social barriers interfering with the practitioner's ability to execute a medically necessary plan of care.

Practitioners and their staff of auxiliary personnel sometimes obtain information about and help address social determinants of health (SDOH) that significantly impact the practitioner's ability to diagnose or treat a patient. Additionally, practitioners and their staff sometimes help newly diagnosed cancer patients and other patients with similarly serious, high-risk illnesses navigate their care, such as helping them to understand and implement the plan of care and locate and reach the right providers to access recommended treatments and diagnostic services, considering the personal circumstances of each patient.

Payment for these activities, to the extent they are reasonable and necessary for the diagnosis and treatment of the patient's illness or injury, is currently included in payment for other services such as evaluation and management (E/M) visits and some care management services.

Medical practice has evolved to increasingly recognize the importance of these activities and CMS believes practitioners are performing them more often. However, this work is not explicitly identified in current coding, so they believe it is underutilized and undervalued.

CMS has sought to create new coding to expressly identify and value these services for PFS payment and distinguish them from current care management services.

In the CY 2023 PFS final rule CMS issued a Request for Information (RFI) related to Medicare Part B Payment for services involving community health workers (CHWs).

For CY 2024, they considered how they could better recognize, through coding and payment policies, when members of an interdisciplinary team, including CHWs, are involved in treatment of Medicare beneficiaries. Currently, no separately specified statutory Medicare benefit category provides direct payment to CHWs for their services.

Additionally, current HCPCS coding does not specifically identify services provided by CHWs, even though CHWs may facilitate access to healthcare through community-based services that are necessary to alleviate barriers to care that are interfering with a practitioner's ability to diagnosis or treat an illness or injury.

In addition, in 2021, the AMA CPT Editorial Panel recognized in the CPT E/M Guidelines that SDOH needs can increase complexity of a practitioner's medical decision making (MDM) for an E/M visit and increase risk to the patient when diagnosis or treatment is significantly limited by SDOH.

Practitioners are increasingly expending resources to obtain information from the patient about SDOH and risks and formulate diagnosis and treatment plans that consider these needs. CMS believes that social workers, CHWs, and other auxiliary personnel are currently performing some of these activities and that the resources involved in these activities are not reflected in current coding and payment policies.

As such, CMS believes it is appropriate to create codes to separately identify and more accurately value this work.

CMS has created new HCPCS codes and established payment rates under the PFS for three types of services that may be provided by auxiliary personnel incident to the billing physician or practitioner's professional services, and under the billing practitioner's supervision, when reasonable and necessary to diagnose and treat the patient:

- Community Health Integration (CHI) services
- Social determinants of health (SDOH) risk assessment, and
- Principal Illness Navigation (PIN) services

These three new service types are discussed in the following sections.

Community Heath Integration (CHI) Services

New HCPCS codes G0019 and G0022 describe community health integration (CHI) services performed by certified or trained auxiliary personnel, which may include a Community Health Worker (CHW), incident to the professional services of and under the general supervision of the billing practitioner.

HCPCS G0019 is billed for the first 60 minutes CHI services and add-on code G0022 is reported for each additional 30 minutes.

●G0019 Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit:

- Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit.

  ++ Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet sdoh needs (that are not separately billed).

  ++ Facilitating patient-driven goal-setting and establishing an action plan.

  ++ Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.

- Practitioner, home-, and community-based care coordination.

  ++ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable).

  ++ Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.

  ++ Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up

after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.

++ Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s).

- Health education- helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s), and educating the patient on how to best participate in medical decision-making.
- Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment.
- Health care access / health system navigation.

  ++ Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.
- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
- Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.
- Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

●G0022 Community health integration services, each additional 30 minutes per calendar month (list separately in addition to g0019)

CHI services may be furnished monthly, as medically necessary, following an initiating E/M visit (CHI initiating visit) in which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner’s ability to diagnose or treat the problem(s) addressed in the visit.

A CHI initiating visit can be an E/M visit (other than a low-level E/M visit that can be performed by clinical staff) performed by the billing practitioner who would also be furnishing the CHI services during the subsequent calendar month(s), including an E/M visit furnished as part of TCM, or an AWV.

The subsequent CHI services would be performed by auxiliary personnel (including registered nurses and social workers) incident to the professional services of the practitioner who bills the CHI initiating visit.

CMS is designating CHI as care management services that may be furnished under general supervision.

All auxiliary personnel who provide CHI services must be certified or trained to perform all included service elements and authorized to perform them under applicable State laws and regulations.

Patient consent is required in advance of providing CHI services, and may be obtained either in writing or verbally, so long as the consent is documented in the patient's medical record.

The billing practitioner may arrange to have CHI services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of the "incident to" and other requirements and conditions for payment of CHI services are met, and there must be sufficient clinical integration between the third party and the billing practitioner in order for the services to be fully provided.

CHI services cannot be billed while the patient is under a home health plan of care under Medicare Part B.

CMS emphasizes that CHI is covered and paid under the Medicare program when there are SDOH needs that are interfering with the billing clinician's diagnosis and treatment of the patient. These services are meant to resolve those specific concerns to facilitate the patient's medical care, which would distinguish CHI from other social services and programs that may be available through Medicaid State plans or other State or community programs.

Social Determinants of Health (SDOH) Risk Assessment

New HCPCS G0136 is established for reporting the administration of a standardized, evidence-based SDOH risk assessment tool.

●G0136 Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes

SDOH risk assessment refers to a review of the individual's SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions. HCPCS G0136 describes the work involved in the administration of an SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E/M visit.

SDOH risk assessment through a standardized, evidence-based tool can more effectively and consistently identify unmet SDOH needs and enable comparisons across populations. For example, through administration of the SDOH risk assessment for a patient presenting for diabetes management, a practitioner might discover that a patient's living situation does not permit reliable access to electricity, impacting the patient's ability to keep insulin refrigerated. The practitioner may then prescribe a type of insulin that remains stable at room temperature or consider oral medication instead.

Use of this code requires administration of a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.

Billing practitioners may choose to assess for additional domains beyond those listed above if there are other prevalent or culturally significant social determinants in the community being treated by the practitioner.

Possible evidence-based tools include the CMS Accountable Health Communities (AHC) tool, the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) tool, and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment.

Any standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research may be used to conduct the SDOH risk assessment

In addition to an outpatient E/M visit (other than a level 1 visit by clinical staff), SDOH risk assessment can be furnished with CPT code 90791 (Psychiatric diagnostic evaluation) and the Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168. HCPCS code G0136 may also be performed in conjunction with an Annual Wellness Visit (AWV).

HCPCS code G0136 may also be furnished with hospital discharge visits, to remain consistent with other CMS policies promoting assessment of SDOH as an indicator of quality care and to promote safe discharge planning.

CMS is not finalizing their initially proposed requirement that the practitioner who furnishes the SDOH risk assessment must also have the capacity to furnish CHI, PIN, other care management services, or have partnerships with CBOs.

They do expect that the practitioner furnishing an SDOH risk assessment would, at a minimum, refer the patient to relevant resources and consider the results of the assessment in their medical decision making or diagnosis and treatment plan for the visit.

Any SDOH need identified during HCPCS code G0136 must be documented in the medical record. CMS is not requiring the use of diagnosis Z-codes for documentation, though they have suggested that use of Z-codes would be appropriate to document SDOH needs in the medical record and encourage the use of Z-codes across CMS programs to better understand the needs of beneficiaries.

CMS has finalized a limitation on payment for the SDOH risk assessment service of once every 6 months per practitioner per beneficiary.

Principal Illness Navigation (PIN) Services

CMS says that experts on navigation of treatment for cancer and other high-risk, serious illnesses have demonstrated the benefits of navigation services for patients experiencing these conditions, especially those with socioeconomic disadvantages or barriers to care.

Principal Illness Navigation (PIN) refers to providing individualized help to the patient (and caregiver, if applicable) to identify appropriate practitioners and providers for care needs and support, and access necessary care timely, especially when the landscape is complex and delaying care can be deadly.

It is often referred to in the context of patients diagnosed with cancer or another severe, debilitating illness, and includes identifying or referring to appropriate supportive services.

Certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer specialist, are involved in the patient's health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/ decompensation, functional decline, or death.

Examples of serious, high-risk diseases for which patient navigation services could be reasonable and necessary include cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder (SUD).

The definition of a serious, high-risk condition is dependent on clinical judgement and the list of conditions provided is not exhaustive. Additional conditions such as chronic liver disease, chronic kidney disease, stroke, and conditions that require stem cell transplantation could all meet the outlined definition depending on the specific severity of the illness in individuals with these conditions.

HCPCS G0023 is billed for the first 60 minutes of PIN services and add-on code G0024 is reported for each additional 30 minutes.

●G0023 Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:

- Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition.

  ++ Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet sdoh needs (that are not separately billed).

  ++ Facilitating patient-driven goal setting and establishing an action plan.

  ++ Providing tailored support as needed to accomplish the practitioner's treatment plan.

- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.

- Practitioner, home, and community-based care coordination.

  ++ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable).

  ++ Communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.

  ++ Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.

  ++ Facilitating access to community-based social services (e.g., housing, utilities, transportation, likely to promote personalized and effective treatment of their condition.

- Health care access / health system navigation.

  ++ Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them.

++ Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable.

- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
- Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.
- Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

●G0024 Principal illness navigation services, additional 30 minutes per calendar month (list separately in addition to G0023)

Like CHI services, PIN services require an initiating visit which could be an E/M visit (other than a low-level E/M visit that can be performed by clinical staff) performed by the billing practitioner who will also be furnishing the PIN services during the subsequent calendar month(s). CPT code 90791 (Psychiatric diagnostic evaluation) and the Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168 also qualify as initiating visits for PIN services.

The annual wellness visit (AWV) may serve as an initiating visit for PIN services when the AWV is furnished by a practitioner who has identified in the AWV a high-risk condition(s) that would qualify for PIN services.

The PIN initiating visit would serve as a pre-requisite to billing for PIN services, during which the billing practitioner would identify the medical necessity of PIN services and establish an appropriate treatment plan. The subsequent PIN services would be performed by auxiliary personnel incident to the professional services of the practitioner who bills the PIN initiating visit.

SDOH needs are not required for use PIN services but may be applicable.

CMS has designated PIN services as care management services that may be furnished under general supervision.

The length of time between suspicion (such as a positive screening test) and definitive diagnosis can stretch into weeks for some conditions, and navigation services of a "high risk condition" does not exclude conditions without a definitive diagnosis. As such, a practitioner could exercise clinical judgement and determine that it represents a serious high-risk condition for that patient, and that PIN services should be furnished as part of the early treatment plan.

After CMS proposed these new codes, many commenters stated that, while they are certified and trained to perform many of the activities listed in the code descriptor, care coordination activities fall outside the scope of certified peer support specialists. The requirement that auxiliary personnel performing PIN services be certified or trained to perform all activities would effectively exclude peer support specialists from performing PIN services.

These commenters discussed that beneficiaries with severe mental illness and SUD would benefit from the significant set of activities described for PIN services that peer specialists are qualified to perform and urged CMS to create unique coding for PIN performed by peer support specialists, removing the requirements that fall outside of peer support specialist expertise.

As a result of these concerns, CMS has established two additional HCPCS G-codes to describe Principal Illness Navigation – Peer Support (PIN-PS). Given the nature of work typically performed by peer support specialists, CMS is limiting these codes to the treatment of behavioral health conditions that otherwise satisfy the definition of a high-risk condition(s).

●G0140 Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:

- Person-centered interview, performed to better understand the individual context of the serious, high-risk condition.

  ++ Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet sdoh needs (that are not billed separately).

  ++ Facilitating patient-driven goal setting and establishing an action plan.

++ Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan.

- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.
- Practitioner, home, and community-based care communication.

  ++ Assist the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors.

  ++ Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).

- Health education. helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and sdoh need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.
- Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.
- Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals.
- Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals.
- Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

●G0146 Principal illness navigation - peer support, additional 30 minutes per calendar month (list separately in addition to G0140)

Patients with behavioral health conditions can still receive HCPCS code G0023 and G0024 services, so long as the auxiliary staff providing them are trained and certified in all parts of those code descriptors.

CMS is not finalizing a frequency limitation for the services described by HCPCS codes G0024 or G0146 and will monitor utilization of these codes going forward to ascertain the time spent per month per PIN service.

CMS is also not limiting the duration of PIN services but is finalizing a requirement that a new initiating visit be conducted once per year.

Auxiliary personnel must meet any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished.

Many States have applicable rules and certifications, and there are existing certification programs for navigators working in certain settings of care or with specified conditions, such as cancer navigators, diabetes navigators, cardiovascular navigators, mental health navigators, geriatric care navigators, pediatric navigators, social worker navigators, primary care navigators, general patient advocate navigators, and nurse navigators in ambulatory settings.

For peer support specialists, approximately 48 States have professional certification programs for those providing services to patients with substance use or mental health conditions. States may include qualified peer support specialists in their Medicaid programs.

For States with no applicable State requirements, the training and certification for auxiliary personnel providing HCPCS codes G0023 and G0024 must include the competencies of patient and family communication, interpersonal and relationship-building, patient and family capacity building, service coordination and systems navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and the development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition/illness/disease addressed in the initiating visit.

For PIN-PS (HCPCS codes G0140 and G0146), if no applicable State requirements exist, training must be consistent with the National Model Standards for Peer Support Certification published by SAMHSA. This is the most universally recognized standard for peer support specialists in the country and was developed and is maintained by SAMHSA, who has an expertise in this area.

PIN services are reportable “per condition,” rather than the patient only being able to have one PIN service at a time.

Time spent furnishing PIN services must be documented in the medical record in its relationship to the serious, high-risk illness.

The activities performed by the auxiliary personnel, and how they are related to the treatment plan for the serious, high-risk condition, would be described in the medical record, just as all clinical care is documented in the medical record.

CMS requires identified SDOH need(s), if present, to be recorded in the medical record, and for data standardization, practitioners would be encouraged to record the associated ICD-10 Z-code (Z55-Z65) in the medical record and on the claim.

Patient consent is required for PIN services, and that consent can be written or verbal, so long as it is documented in the patient’s medical record. Consent must be obtained annually and may be obtained by the auxiliary personnel either before or at the time they begin performing PIN services for the patient.

PIN and PIN-PS should not be billed concurrently for the same serious, high-risk condition. However, practitioners furnishing PIN services may bill care management services as appropriate for managing and treating a patient's illness.

Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) Services

Section 4124(b) of the CAA, 2023 established Medicare coverage for intensive outpatient services effective for items and services furnished on or after January 1, 2024.

Three existing HCPCS G-codes specific to partial hospitalization programs (PHPs) are revised for 2024 to also be applicable to intensive outpatient programs (IOPs).

▲G0129 Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization or intensive outpatient treatment program, per session (45 minutes or more)

▲G0410 Group psychotherapy other than of a multiple-family group, in a partial hospitalization or intensive outpatient setting, approximately 45 to 50 minutes

▲G0411 Interactive group psychotherapy, in a partial hospitalization or intensive outpatient setting, approximately 45 to 50 minutes

New HCPCS G0137 is established for reporting IOP services furnished by opioid treatment programs (OTPs). CMS has added "opioid use disorder treatment service" to the definition of items and services furnished by OTPs and defined a new category of services called "OTP intensive outpatient services."

Reporting G0137 results in an adjustment to the bundled payment for OTP services when at least nine services of OTP intensive outpatient services are furnished in a week.

●G0137 Intensive outpatient services; weekly bundle, minimum of 9 services over a 7 contiguous day period, which can include individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under state law); occupational therapy requiring the skills of a qualified occupational therapist; services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; individualized activity therapies that are not primarily recreational or diversionary; family

counseling (the primary purpose of which is treatment of the individual's condition); patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment); diagnostic services; and such other items and services (excluding meals and transportation) that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services in accordance with a physician certification and plan of treatment (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure

See the 2024 OPPS Final Rule for a detailed discussion regarding this new code.

Behavioral Health Integration Care Management

Existing HCPCS G0323 which describes behavioral health care management services is revised for 2024 to allow two new provider types.

As discussed in the CY 2024 PFS final rule, section 4121(a)(1) of the CAA, 2023, added a new benefit category under Medicare Part B to include marriage and family therapist services and mental health counselor services.

As such, the descriptor of HCPCS G0323 is revised to include mental health counselors and marriage or family therapists as providers eligible to furnish this service.

▲G0323	Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist, ~~or~~ clinical social worker, mental health counselor, or marriage and family therapist time, per calendar month. (These services include the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team)

Remote Interrogation Device Evaluation – Cardiovascular

For CY 2020 the AMA deleted CPT 93299, which was used to report the technical component of remote monitoring services described by CPT codes 93297 for cardiovascular physiologic monitors and 93298 for subcutaneous cardiac rhythm monitors, which are shown below.

93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional

The AMA determined that there were significant differences in clinical staff time and work required for these two services and it cannot be appropriately captured in a single technical code.

The AMA recommended that CPT codes 93297 and 93298 be revalued to include the work associated with 93299.

However, CMS did not agree with the recommended values and decided to not allocate direct PE inputs for CPT codes 93297 or 93298. Instead, CMS created contractor priced HCPCS code G2066 for CY 2020 to ensure that services which were previously described under CPT code 93299 could still be furnished.

Since the publication of the CY 2020 PFS final rule, HCPCS code G2066 has remained contractor priced and CPT codes 93297 and 93298 have remained as work-only codes. However, interested parties have indicated that a long-term solution is needed from CMS to help establish payment stability for these services.

For CY 2024, CMS has decided to delete HCPCS G2066 and establish direct PE-inputs for CPT codes 93297 and 93298 based on the AMA recommendations. The services which were previously billed under HCPCS code G2066 will now be billed under existing CPT codes 93297 and 93298.

~~G2066~~ ~~Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, implantable loop recorder system, or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results~~

Medicare Diabetes Prevention Program (MDPP)

The Medicare Diabetes Prevention Program (MDPP) is an evidence-based behavioral intervention that aims to prevent or delay the onset of type 2 diabetes for eligible Medicare beneficiaries diagnosed with prediabetes.

MDPP was established in 2017 as an "additional preventive service" covered by Medicare and not subject to beneficiary cost-sharing, in addition to being available once per lifetime to eligible beneficiaries.

To facilitate delivery of MDPP in a non-clinical community setting, CMS created a new MDPP supplier type through rulemaking in the CY 2017 PFS final rule, in addition to requiring organizations that wish to participate in MDPP to enroll in Medicare separately, even if they are already enrolled in Medicare for other purposes.

As discussed in the 2024 OPPS Final Rule, CMS has established three new HCPCS G-codes reportable by MDPP providers that are meant to simplify reporting and reduce administrative burden.

Codes G9886 and G9887 are reported for patient's attendance at an MDPP core or core maintenance session, either in person, or via distance learning.

- G9886 Behavioral counseling for diabetes prevention, in-person, group, 60 minutes
- G9887 Behavioral counseling for diabetes prevention, distance learning, 60 minutes

HCPCS G9888 is reportable along with the monthly session claim for beneficiaries who have met the 5 percent weight loss performance goal.

- G9888 Maintenance 5% wl from baseline weight in months 7-12

Tables 49 and 50 on the following page are taken from the CY 2024 OPPS final rule and list the CY 2023 MDPP payment structure and the simplified payment structure beginning in CY 2024 which includes these new codes. See the CY 2024 OPPS final rule for more details on the MDPP program and reporting requirements for these codes.

TABLE 50: CY 2023 MDPP Payment Structure

HCPCS G-Code	Payment Description	CY 2023
	Core Sessions (Months 1-6)	
G9873	Attend 1 Core Session	$38
G9874	Attend 4 Core Sessions	$115
G9875	Attend 9 Core Sessions	$191
	Core Maintenance (CM) Sessions (Months 7-12)	
G9876	Attend 2 Core Maintenance Sessions (No 5% WL) in CM Interval 1 (Months 7-9)	$76
G9877	Attend 2 Core Maintenance Sessions (No 5 percent WL) in CM Interval 2 (Months 10-12)	$76
G9878	Attend 2 Core Maintenance Sessions (5 percent WL) in CM Interval 1 (Months 7-9)	$101
G9879	Attend 2 Core Maintenance Sessions (5 percent WL) in CM Interval 2 (Months 10-12)	$101
G9880	5 percent WL Achieved from baseline weight	$184
G9881	9 percent WL Achieved from baseline weight	$38
G9890	Bridge Payment	$38
G9891	Non-payable session code (This code is for reporting purposes only).	$0
	Ongoing Maintenance Sessions (Months 7-12)**	
G9882	Attend 2 Ongoing Maintenance (OM) Sessions in OM Interval 1 (Months 13-15)	$57
G9883	Attend 2 Ongoing Maintenance Sessions in OM Interval 2 (Months 16-18)	$57
G9884	Attend 2 Ongoing Maintenance Sessions in OM Interval 3 (Months 19-21)	$58
G9885	Attend 2 Ongoing Maintenance Sessions in OM Interval 4 (Months (22-24)	$58
Subtotal Maximum Attendance-Based Payment		**$496**
Total Maximum Payment		**$768**

**In the CY 2022 PFS, CMS removed the Ongoing Maintenance Sessions for those beneficiaries who started MDPP services on or after January 1, 2022. MDPP beneficiaries who were participating in the Set of MDPP services on or before December 31, 2021 may continue with the ongoing maintenance phase if they maintain 5 percent weight loss and attendance requirements.

TABLE 49: Changes to MDPP Payment Structure to include Attendance-Based Service Payments and Diabetes Risk Reduction Performance Payments

HCPCS G-Code	Payment Description*	CY 2024
G9886*	Behavioral counseling for diabetes prevention, in-person, group, 60 minutes	$25
G9887*	Behavioral counseling for diabetes prevention, distance learning, 60 minutes	$25
G9880	5 percent WL Achieved from baseline weight	$145
G9881	9 percent WL Achieved from baseline weight	$25
G9888**	Maintenance 5 percent WL from baseline in months 7-12	$8
G9890	Bridge Payment	$25
Subtotal Maximum Attendance-Based Payment		**$550**
Total Maximum Payment		**$768**

**Medicare pays up to 22 sessions billed with codes G9886 and G9887, combined, in a 12-month period: Months 1-6: 1 in-person or distance learning session every week (max 16 sessions)*
Months 7-12: 1 in-person or distance learning session every month (max 6 sessions)
*** Suppliers must submit claim for 5 percent weight loss (G9880) prior to submitting claims for the maintenance 5 percent WL from baseline in months 7-12 (G9888).*

Drugs and Biologicals – "J" Codes

- 33 new codes
- One deleted code
- One revised code description

HCPCS J-codes are permanent codes that describe drugs and biologicals, including injectable drugs and oral chemotherapy and antiemetic drugs.

There are 33 new HCPCS J-codes for drugs and biologicals effective January 1, 2024, as shown in the table below. Some are replacement codes for deleted temporary HCPCS C-codes, while others are entirely new. Note the continued addition of new HCPCS codes for single source drugs (e.g., J0688 for a single source version of cefazolin sodium).

*HCPCS J0750, J0751, and J0799 shown in the table below have no OPPS status indicator shown. They were published as new codes in the annual HCPCS release but were not included in Addendum B of the OPPS final rule.

HCPCS	SI	Long Description
J0184	G	Injection, amisulpride, 1 mg
J0217	G	Injection, velmanase alfa-tycv, 1 mg
J0391	K	Injection, artesunate, 1 mg
J0402	G	Injection, aripiprazole (abilify asimtufii), 1 mg
J0576	G	Injection, buprenorphine extended-release (brixadi), 1 mg
J0688	N	Injection, cefazolin sodium (hikma), not therapeutically equivalent to j0690, 500 mg
J0750*	#N/A	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)
J0751*	#N/A	Emtricitabine 200mg and tenofovir alafenamide 25mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)
J0799*	#N/A	Fda approved prescription drug, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv), not otherwise classified
J0873	N	Injection, daptomycin (xellia) not therapeutically equivalent to j0878, 1 mg
J1105	K	Dexmedetomidine, oral, 1 mcg
J1246	K	Injection, dinutuximab, 0.1 mg
J1304	G	Injection, tofersen, 1 mg
J1412	G	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^13 vector genomes

HCPCS	SI	Long Description
J1413	G	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose
J1596	N	Injection, glycopyrrolate, 0.1 mg
J1939	N	Injection, bumetanide, 0.5 mg
J2404	N	Injection, nicardipine, 0.1 mg
J2508	G	Injection, pegunigalsidase alfa-iwxj, 1 mg
J2679	N	Injection, fluphenazine hcl, 1.25 mg
J2799	G	Injection, risperidone (uzedy), 1 mg
J3401	G	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml
J3425	N	Injection, hydroxocobalamin, 10 mcg
J9052	K	Injection, carmustine (accord), not therapeutically equivalent to j9050, 100 mg
J9072	G	Injection, cyclophosphamide, (dr. reddy's), 5 mg
J9172	E2	Injection, docetaxel (ingenus) not therapeutically equivalent to j9171, 1 mg
J9255	E2	Injection, methotrexate (accord) not therapeutically equivalent to j9250 and j9260, 50 mg
J9258	N	Injection, paclitaxel protein-bound particles (teva) not therapeutically equivalent to j9264, 1 mg
J9286	G	Injection, glofitamab-gxbm, 2.5 mg
J9321	G	Injection, epcoritamab-bysp, 0.16 mg
J9324	E2	Injection, pemetrexed (pemrydi rtu), 10 mg
J9333	G	Injection, rozanolixizumab-noli, 1 mg
J9334	K	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc

Existing HCPCS J0739 is revised for 2024 to specify use for HIV pre-exposure prophylaxis, not for use as treatment for HIV.

▲J0739 Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)

Existing HCPCS J9160 for denileukin diftitox is deleted for 2024 with no replacement code. This code was established to describe the drug ONTAK®, which was withdrawn from the U.S. market in 2014 and has not been marketed or available in the United States for nearly ten years.

~~J9160 Injection, denileukin diftitox, 300 micrograms~~

Temporary Codes Assigned to DME Regional Carriers – "K" Codes

- 25 deleted codes

CMS occasionally establishes temporary HCPCS K-codes for use by DME MACs when existing permanent national codes do not include codes needed to implement a DME MAC policy. CMS is committed to migrating these codes, when appropriate, into permanent HCPCS code categories.

25 temporary HCPCS K-codes which were established between 2020 and 2022 are deleted for 2024 and replaced with permanent HCPCS A-codes, E-codes, or L-codes, as shown in the table below.

HCPCS	Long Description	Replacement Code
K1001	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type	E0530
K1002	Cranial electrotherapy stimulation (ces) system, any type	E0732
K1003	Whirlpool tub, walk-in, portable	E1301
K1005	Disposable collection and storage bag for breast milk, any size, any type, each	A4287
K1006	Suction pump, home model, portable or stationary, electric, any type, for use with external urine management system	E2001
K1009	Speech volume modulation system, any type, including all components and accessories	E3000
K1013	Enema tube, with or without adapter, any type, replacement only, each	A4457
K1014	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control	L5615
K1015	Foot, adductus positioning device, adjustable	L3161
K1016	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve	E0733
K1017	Monthly supplies for use of device coded at k1016	A4541
K1018	External upper limb tremor stimulator of the peripheral nerves of the wrist	E0734
K1019	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	A4542
K1020	Non-invasive vagus nerve stimulator	E0735
K1021	Exsufflation belt, includes all supplies and accessories	A4468

HCPCS	Long Description	Replacement Code
K1022	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type	L5926
K1023	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	A4540
K1024	Non-pneumatic compression controller with sequential calibrated gradient pressure	E0680
K1025	Non-pneumatic sequential compression garment, full arm	E0682
K1026	Mechanical allergen particle barrier/inhalation filter, cream, nasal, topical	A7023
K1028	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application	E0492
K1029	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply	E0493
K1031	Non-pneumatic compression controller without calibrated gradient pressure	E0681
K1032	Non-pneumatic sequential compression garment, full leg	E0678
K1033	Non-pneumatic sequential compression garment, half leg	E0679

Prosthetic and Orthotic Supplies, Devices and Implants – "L" Codes

- Three new codes

HCPCS L-codes describe orthotic and prosthetic supplies, devices, and implants.

There are three new codes established for 2024. Each is for durable medical equipment, replacing a temporary HCPCS K-code, as discussed in the previous section.

HCPCS	SI	Long Description
L3161	Y	Foot, adductus positioning device, adjustable
L5615	Y	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control
L5926	Y	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type

Medical Services – "M" Codes

- 160 new codes
- Three deleted codes
- 10 revised code descriptions

HCPCS M-codes are used to report miscellaneous medical services. Prior to 2019, there were just six active HCPCS M-codes. However, in recent years many new HCPCS M-codes have been established, mostly for quality reporting.

Physician Quality and Data Reporting Codes

Like the HCPCS G-code set, the set of HCPCS M-codes also contains codes for physician quality and data reporting.

There are 160 new, three deleted, and nine revised quality reporting codes, as shown in the table that accompanies this manual (assigned statis indicator M "Items and Services Not Billable to the Fiscal Intermediary" under the OPPS).
.

In-Home Administration of Preventive Vaccines

During the COVID-19 PHE, CMS established HCPCS M0201 to allow for an additional payment for the administration of a COVID-19 vaccine in a patient's home, under certain circumstances.

Providers and suppliers that administered a COVID-19 vaccine in the home would bill Medicare for one of the existing COVID-19 vaccine administration CPT codes along with HCPCS code M0201.

CMS has revised the description of HCPCS M0201 to also include home administration of other Medicare preventive vaccines including pneumococcal, influenza, and hepatitis B vaccines.

▲M0201 ~~COVID-19 vaccine administration~~ Administration of pneumococcal, influenza, hepatitis b, and/or covid-19 vaccine inside a patient's home; reported only once per individual home~~,~~ per date of service when ~~only COVID-19 vaccine administration is~~ such vaccine administration(s) are performed at the patient's home

CMS has established certain conditions for the add-on payment described by HCPCS code M0201.

For purposes of this add-on payment, the following requirements apply:

- The patient has difficulty leaving the home or faces barriers to getting a vaccine in settings other than their home.
- The sole purpose of the visit is to administer one or more preventive vaccines.
- The home is not an institution that meets the requirements of sections 1861(e)(1), 1819(a)(1), or 1919(a)(1) of the Act, which includes hospitals and skilled nursing facilities (SNFs), as well as most nursing facilities under Medicaid.

To meet requirements for billing HCPCS code M0201, a vaccine must be administered inside an individual's home. For this purpose, an individual unit in a multi dwelling building is considered a home. For example, an individual apartment in an apartment complex or an individual bedroom inside an assisted living facility or group home is considered a home.

HCPCS code M0201 can be billed only once per individual home per date of service, even if multiple vaccines are administered during the same home visit.

Medicare pays the additional payment amount for up to a maximum of 5 vaccine administration services per home unit or communal space within a single group living location; but only when fewer than 10 Medicare patients receive a COVID-19 vaccine dose on the same day at the same group living location.

When 10 or more Medicare patients get a vaccine dose at a group living location on the same day, you can only bill for the additional payment once per home (whether the home is an individual living unit or a communal space).

Temporary – "Q" Codes

- 22 new codes
- Two revised code descriptions

HCPCS Q-codes are used to identify services that would not be given a CPT code, such as drugs, biologicals, and other types of medical equipment or services, and which are not identified by national level II codes, but for which codes are needed for claims processing purposes.

Drugs and Biologicals

Three new HCPCS Q-codes are established for reporting the supply of an HIV prophylaxis FDA approved prescription drug in 30-, 60-, or 90-day supplies.

As discussed on page **119** of this manual, a new national coverage determination is forthcoming from CMS related to the covered of pre-exposure prophylaxis (PrEP) using antiretroviral therapy to prevent HIV infection. These HCPCS were not included in the OPPS or PFS final rules and have no published status indicator or other coverage information as of the time of the publication of this manual.

●Q0516	Pharmacy supplying fee for HIV pre-exposure prophylaxis FDA approved prescription drug, per 30-days
●Q0517	Pharmacy supplying fee for HIV pre-exposure prophylaxis FDA approved prescription drug, per 60-days
●Q0518	Pharmacy supplying fee for HIV pre-exposure prophylaxis FDA approved prescription drug, per 90-days

New HCPCS Q5132 is established effective January 1, 2024 at the request of Pfizer to report the drug ABRILADA™, an adalimumab biosimilar product.

●Q5132	Injection, adalimumab-afzb (abrilada), biosimilar, 10 mg

Skin Substitute Products

Existing HCPCS Q4225 for Amniobind is revised for 2024 to also be reportable for DermaBind™ TL. DermaBind TL is identical in every aspect to AmnioBind, except the product name and manufacturer name.

▲Q4225 Amniobind or dermabind tl, per square centimeter

Additionally, there are 14 new HCPCS codes for skin substitute products effective January 1, 2024, as shown in the table below.

HCPCS	Long Description
Q4279	Vendaje ac, per square centimeter
Q4287	Dermabind dl, per square centimeter
Q4288	Dermabind ch, per square centimeter
Q4289	Revoshield + amniotic barrier, per square centimeter
Q4290	Membrane wrap-hydro, per square centimeter
Q4291	Lamellas xt, per square centimeter
Q4292	Lamellas, per square centimeter
Q4293	Acesso dl, per square centimeter
Q4294	Amnio quad-core, per square centimeter
Q4295	Amnio tri-core amniotic, per square centimeter
Q4296	Rebound matrix, per square centimeter
Q4297	Emerge matrix, per square centimeter
Q4298	Amnicore pro, per square centimeter
Q4299	Amnicore pro+, per square centimeter
Q4300	Acesso tl, per square centimeter
Q4301	Activate matrix, per square centimeter
Q4302	Complete aca, per square centimeter
Q4303	Complete aa, per square centimeter
Q4304	Grafix plus, per square centimeter

Home IVIG Administration

HCPCS Q2052 was established in 2014 to report services, supplies, and accessories used for home administration of IVIG under the Medicare IVIG demonstration.

The demonstration was implemented to evaluate the benefits of providing payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of primary immune deficiency disease (PIDD).

The demonstration was most recently extended for an additional three years and will end on December 31, 2023.

Section 4134 of the CAA, 2023 makes the IVIG in-home coverage permanent, with no need for patients or eligible suppliers to enroll in the demonstration. HCPCS Q2052 is revised to no longer refer to the demonstration.

▲Q2052 Services, supplies and accessories used in the home ~~under the Medicare intravenous immune globulin (IVIG) demonstration~~ for the administration of intravenous immune globulin (IVIG)

This HCPCS is reported by DMEPOS suppliers.

Private Payer – "S" Codes

- Two deleted codes

HCPCS S-codes are primarily used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing. They are for the purpose of meeting the particular needs of the private sector. These codes may also be used by Medicaid programs, but they are not payable by Medicare.

Two HCPCS S-codes for drugs are deleted due to the establishment of permanent HCPCS J-codes.

HCPCS S0166 for olanzapine is deleted due to the establishment of HCPCS J2359 (Injection, olanzapine, 0.5 mg) effective October 1, 2023. It is important to note that the new HCPCS J-code is billed per 0.5 mg as opposed to per 2.5 mg.

~~S0166~~ ~~Injection, olanzapine, 2.5 mg~~

Note: The January 2024 HCPCS release shows S0166 being deleted effective September 30, 2023, however it was not identified as such in the October 2023 HCPCS release.

HCPCS S0171 for bumetanide is deleted due to the establishment of HCPCS J1939 (Injection, bumetanide, 0.5 mg) effective January 1, 2024.

~~S0171~~ ~~Injection, bumetanide, 0.5 mg~~

National Codes for State Medicaid Agencies – "T" Codes

- One revised code description

A single change is made to the set of HCPCS T-codes, which are established for use by state Medicaid agencies.

Existing HCPCS T1026 is editorially revised to correct the erroneous description that listed "medical" twice instead of medical and "mental."

▲T1026	Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, ~~medical~~ mental and psychosocial impairments, per hour

Part III: Master Table of All CPT/HCPCS Changes

See table provided as an appendix to this manual

Profile of Services

At IRI, we provide an integrated suite of solutions to ensure that your facility is maximizing reimbursement in compliance with regulatory guidance. Our dedicated team of expert consultants has decades of experience educating healthcare facilities, analyzing data, and recommending/implementing process improvements. We have worked with hospitals and other healthcare facilities across the country, implementing best practices to ensure charge integrity. Our solutions assist facilities of any size to ensure the integrity of their revenue. Each service can be individually tailored to meet your specific needs.

COMPREHENSIVE CHARGE MASTER REVIEWS

The Charge Description Master (CDM) is an essential tool for organizational success. CDM reviews ensure complete, accurate, and compliant Charge Master files. Our comprehensive reviews also analyze charge capture processes to ensure that charges are being captured accurately and efficiently. If needed, we can also map all charges from the CDM to order entry dictionaries or other points of charge generation to review for accuracy.

REVENUE INTEGRITY AUDITS

Revenue Integrity Audits identify opportunities or deficiencies by analyzing the flow of charges from the point of order through to third-party adjudication. Audits include review of orders, documentation, claim forms, and third-party remittance advice to ensure that every encounter is documented and billed appropriately.

ANNUAL CONSULTING RETAINER

Researching important matters related to regulatory guidance, billing, coding, and reimbursement can be a full-time job. Our annual retainer service provides access to expert consultant answers related to all routine inquiries throughout the year. Answers are provided quickly, and with supporting CMS, coding and third-party payer guidance, where applicable. IRI consultants share industry best practices, including solutions that have worked for other facilities.

REMOTE CDM MANAGEMENT OR SUPPORT

Ensure sustained accuracy and compliance via remote CDM management or support. The level of engagement our consultants provide depends upon your needs, from fully outsourced CDM management, to consultant review of all CDM change requests. IRI consultants work with facilities to maintain a clean and compliant CDM in real time.

ONSITE OR REMOTE TRAINING

IRI consultants are available to perform on-site or remote training for your revenue cycle staff. Our training programs are developed based on your requirements and needs. Example topics include: Medicare coverage, billing and reimbursement, CDM management, charge capture, denials/edits, and compliance. Customized training materials can be developed and provided to staff.

Integrated Revenue Integrity
225 Cedar Hill Street, Suite 200
Marlborough, MA 01752
508-630-2141 • integratedri.com

Contact
For more information, or to schedule a call to discuss further, please contact:

Sandra Magaw
Principal, Business Development
smagaw@integratedri.com
774-272-1183