

# ASCO<sup>®</sup>

AMERICAN SOCIETY OF CLINICAL ONCOLOGY  
KNOWLEDGE CONQUERS CANCER

## **2021 Coding Updates and Changes: CPT<sup>®</sup>, HCPCS, and ICD-10**

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## Current Procedural Terminology (CPT) Updates

This resource is a summary of the coding changes. For full details and guidelines, please refer to the 2021 American Medical Association CPT Professional Edition.

### Evaluation and Management Services

- CPT® code 99201 (new patient, level 1) will be deleted. 99201 is rarely reported by oncologists, and therefore its deletion will have minimal impact on oncology practices. CPT code 99221 (established patient, level 1) will remain as a reportable service.
- Codes will be selected based on the level of medical decision-making (MDM) of the time performed on the day of the encounter. History and examination will be removed as key components for selecting the level of E/M service. In 2021, history and exam will no longer be used to select an E/M service but still must be performed as medically necessary to report CPT codes 99202-99215.

The medical decision-making elements associated with codes 99202-99215 will consist of three components:

- 1) The number and complexity of problems addressed,
- 2) Amount and/or complexity of data to be reviewed and analyzed, AND
- 3) Risk of complications and/or morbidity or mortality of patient management.

A [new medical decision-making table](#) created by the American Medical Association further outlines the criteria for the E/M code level selection.

- The definition of time has been revised. The definition of time associated with CPT codes 99202-99215 has been revised from the typical face-to-face time to total time spent on the day of the encounter. Total time may include review of tests and medical records, documentation of clinical information, and ordering medications or tests, among other activities performed by the physician or other qualified health care professional. The total time corresponding to CPT codes 99202-99215 has been defined as specific intervals.

[Prolonged Evaluation and Management Services \(99417, G2212, 99358, 99359, 99354, 99555, 99415, 99416\)](#)

- CPT® codes 99417 and G2212 were created to describe a 15-minute prolonged service beyond the time of the primary E/M procedure, with or without direct patient contact. Use G2212 for Medicare beneficiaries.
- CPT® codes 99358, 99359, 99354, and 99355 may no longer be reported with office and outpatient Evaluation and Management Services (99202-99215) on the same day.
- CPT® codes 99415 and 99416 (clinical staff prolonged service) may still be reported with an office or outpatient Evaluation and Management service in 2021.

More information about the changes to the office and outpatient E/M services can be found on [ASCO's Coding and Reimbursement page](#).

#### Add-On Complexity Service (G2211)

The implementation of add-on complexity HCPCS code G2211 **has been suspended** for at least three years. This code will not be active for 2021.

#### Care Management Services

##### Chronic Care Management Services

Chronic Care Management Services (99490, 99491, 99439) are defined by CPT® as services that “requires establishing, implementing, revising, monitoring a care plan for a patient due to medical needs. These patients have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months or until the death of the patient. The condition places the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.”

A new chronic care management service 99439 has been introduced for 2021 and described each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional. CPT® code 99439 mirrors HCPCS code G2058, which was only reportable to Medicare (unless otherwise directed by a payer). HCPCS code G2058 will be replaced by CPT® code 99439 in 2021.

##### Guidelines and Reporting

CPT® code 99439 would be reported with CPT® code 99490 (chronic care management service, first 20 minutes of clinical staff), no more than twice per calendar month.

The following CPT® codes may not be reported with 99439 in the same calendar month: 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99491, 99605, 99606, 99607.

In addition, if service time has been reported with CPT® codes 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607 the work may NOT be counted towards the time of 99439 or 99490. For example, if the physician or QHP already provided an Online Digital E/M service for the patient (CPT® code 99421), that time may *not* be included in the time for the chronic care management service.

CPT® has also updated the list of codes that should not be reported in the same calendar month and for service time for CPT code 99491 (Chronic care management service provided by a physician or qualified healthcare professional).

### Telemedicine

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

In 2020, CMS implemented HCPCS code G2012, which is a brief communication technology-based service of 5-10 minutes of medical discussion. To further support patient care during the pandemic, CMS is implementing HCPCS code G2252 for CY 2021 on an interim basis. G2252 describes a brief communication check in service for an established patient of 11-20 minutes. The service may not have originated from an E/M service within the prior seven days or lead to an E/M service within the next 24 hours. If an E/M service does occur (or did occur), the brief communication would be considered a part of the E/M and not separately reported.

HCPCS codes G2012 and G2252 may be reported to Medicare only, unless otherwise directed by a private payer. Brief communication check in services may be reported to private payers with CPT® codes 99441 or 99442 (telephone evaluation and management services). Check payer policies for guidance on appropriate reporting.

## Medicine

### Special Services, Procedures and Reports

99072: Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a

Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease.

CPT® code 99072 was created in response to the significant additional practice expenses related to activities required to safely provide in-person medical services to patients during a public health emergency. These activities and supplies are over and above those usually included in a medical visit or service.

CMS will not include CPT® code 99072 as a separately payable service in the Medicare Physician Fee Schedule, but rather as a bundled service. The N95 mask will be included in the CMS supply database on an interim basis. In addition, CMS has increased the price of certain supplies.

## Procedures

### Imaging

71271: CT, thorax, low dose for cancer screening without contrast materials

## Guideline Changes

### Care Management Services

Chronic Care Management (CCM Services) and Complex Chronic Care Management (CCCM) Services require establishment, implementation, or monitoring of a comprehensive care plan. In 2021, the criteria for a plan of care have been updated in the CPT® guidelines to provide more clarity.

Plan of Care Criteria			
Specific and measurable goals	Periodically reviewed and updated	Relevant to the patient's well-being and lifestyle	Measurable and timebound

Plans of care may include, but are not limited to the following activities/actions:

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Problem list                    | <input checked="" type="checkbox"/> Medical management                                  |
| <input checked="" type="checkbox"/> Expected outcomes and prognosis | <input checked="" type="checkbox"/> Environmental evaluation                            |
| <input checked="" type="checkbox"/> Measurable treatment goals      | <input checked="" type="checkbox"/> Caregiver assessment                                |
| <input checked="" type="checkbox"/> Cognitive assessment            | <input checked="" type="checkbox"/> Interaction and coordination with outside resources |
| <input checked="" type="checkbox"/> Functional assessment           | <input checked="" type="checkbox"/> Summary of advance directives                       |
| <input checked="" type="checkbox"/> Symptom management              |   |
| <input checked="" type="checkbox"/> Planned interventions           |   |

The plan of care must be documented and shared with the patient/family/caregiver either electronically or in printed form.

### Complex Chronic Care Management Services

Complex Chronic Care Management (CCCM) Services (99487, 99489) are similar to chronic care management services as they both involve establishing, revising, implementing, or monitoring a care plan. However, CCCM services involve decision making of moderate or high complexity and are at least 60 minutes per calendar month.

Complex Chronic Care Management services are provided to patients by clinical staff *under the direction* of a physician or qualified healthcare professional. Like Chronic Care Management Services, the guidelines have been updated with a list of CPT ® codes that may not be reported with CCCM services.

For 2021, the definition of Complex Chronic Care Management Services has been amended to remove the phrases “substantial” and “comprehensive care plan.” Language was also added to further clarify activities surrounding the care plan.

Complex Chronic Care Management Services	
CPT Guidelines 2020	CPT Guidelines 2021
Complex chronic care management services are provided during a calendar month that includes criteria for chronic care management services as well as establishment or substantial revision of a comprehensive care plan...	Complex chronic care management services are provided during a calendar month that includes criteria for chronic care management services including establishing, revising, implementing, or monitoring the care plan...

CPT® clarified which CPT® codes should not be reported during the same calendar month, and for service time, as 99487 and 99489.

Complex Chronic Care Management Services	
CPT Guidelines 2020	CPT Guidelines 2021
Do not report 99487, 99489 during the same calendar month with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99439, 99490, 99491, 99605, 99606, 99607).	Do not report 99487, 99489, 99490 during the same month with 90951-90970, 93792, 93793, 98960-98962, 98966, 98967, 98968, 99071, 99078, 99080, 99091, 99339, 99340, 99358, 99359, 99366-99368, 99374-99380, 99441, 99442, 99443, 99495, 99496, 99605-99607.
N/A	Do not report 99487, 99489 for <u>service time</u> reported with 93792, 93793, 98960,



	98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607).
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### Mastectomy Procedures

Update to guidelines and reporting instructions for Repair/Reconstruction codes 19316-19396.

### Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration

Language in preamble guidelines related to Evaluation and Management services was updated to remove references to CPT® code 99201, which was deleted as of January 1, 2021.

### Non-Face to Face Non-Physician Services

CPT® codes 98966-98968 for telephone services may not be reported with 99439, 99487, 99489, 99490, and 99491.

### Qualified Non-physician Health Care Professional Online Digital Assessment and Management Service

CPT codes® 98970-98972 may not be reported with 99091, 99339, 99340, 99374, 99375, 99377, 99378, 99380, 99439, 99487, 99489, 99490, 99491 for the same communication.

## Healthcare Common Procedure Coding System Update

The Centers for Medicare and Medicaid Services (CMS) publishes updates to the Healthcare Procedure Coding System (HCPCS) on a quarterly basis. Public use files may be downloaded from the "[HCPCS Quarterly Update](#)" page. Be sure to update any systems accordingly.

### Supplies

#### NEW Codes

A9591 Fluoroestradiol F-18, diagnostic, 1 millicurie

C9068 Copper cu-64, dotatate, diagnostic, 1 millicurie

#### DISCONTINUED or REVISED codes

C9060 Fluoroestradiol F-18, diagnostic, 1 millicurie

### Drugs

#### NEW Codes

C9069 Injection, belantamab mafodotin-blmf, 0.5mg

C9070 Injection, tafasitamab-cxix, 2mg

C9073 Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 cap positive viable t-cells, including leukapheresis and dose preparation procedures, per therapeutic dose

#### DISCONTINUED or REVISED Codes

C9062 Injection, daratumumab 10 mg and hyaluronidase-fihj

C9066 Injection, Sacituzumab govitecan-hziy, 2.5 mg

### Procedures

#### New Procedures

G0088 Professional services, initial visit, for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes

G0089 Professional services, initial visit for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes

G0090 Professional services, initial visit, for the administration of intravenous chemotherapy or other highly complex infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes

#### Discontinued Procedure Codes

C9747

G2058 Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

G0297 Low dose CT (LDCT) for lung cancer screening

## ICD-10 CM Updates

The [Centers for Medicare and Medicaid Services](#) published [ICD-10 CM updates](#) effective **October 1<sup>st</sup>, 2021** through **September 30<sup>th</sup>, 2023**. No significant changes are related to neoplasms; however, several codes related to a COVID-19 diagnosis have been added.

A full list of changes can be found in the “Addendum” files on [the ICD-10 CM updates page](#). Questions about ICD-10 CM codes may be sent to ASCO at [practice@asco.org](mailto:practice@asco.org).

## ICD-10 CM Code Set

The Centers for Disease Control and Prevention (CDC) has developed coding guidance for health care encounters and deaths related to the 2019 novel coronavirus (COVID-19).

In certain circumstances, other codes for conditions *not* related to coronavirus may be required in accordance with the [ICD-10-CM Official Guidelines for Coding and Reporting](#). A hyphen at the end of a code indicates an additional character is required.

### Revisions and Updates

Current Language	Revised Language
C93.1 Chronic myelomonocytic leukemia	<i>Added language</i>  Code also, if applicable, eosinophilia (D72.18)
D21.6 Benign neoplasm of connective and other soft tissue of trunk, unspecified:	D21.6 Benign neoplasm of connective and other soft tissue <b>of back, NOS</b>

## Appendix

### ICD-10-CM Terms and Definitions

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

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



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

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

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

## Resources

[ASCO's Guide to 2021 Evaluation and Management Changes](#)

[American Medical Association: CPT® 2021 Professional Edition](#)

[Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies](#)

[CPT® Assistant: COVID-19 Coding Update \(September 8<sup>th</sup>, 2020\)](#)

[2021 ICD-10 CM](#)

[HCPCS Quarterly Updates: January 2021](#)

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