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2017 HEALTHCARE COMMON PROCEDURE CODING SYSTEM

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2017 HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)

With the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standards for Transactions and Code Sets, use of the appropriate medical code sets is required on health care claims.

Effective for dates of service on and after January 1, 2017, the MO HealthNet Division (MHD) will require the 2017 versions of the Current Procedural Terminology (CPT) and the HCPCS medical code sets. Providers should reference the appendix of the CPT and HCPCS books for a summary of the additions, deletions and revisions. For dates of service prior to January 1, 2017, claims must be billed with the 2016 version of CPT and HCPCS codes and modifiers.

HCPCS codes that were deleted by Centers for Medicare & Medicaid Services (CMS) for 2017 are not payable for dates of service January 1, 2017 and after and will be denied. Claims that are submitted and paid for dates of service January 1, 2017 and after using deleted codes for 2017 may be recouped by MHD. Providers may now resubmit/adjust claims for proper payment using the corrected 2017 HCPCS codes. If you have questions concerning how to submit a claim adjustment, please contact Provider Communications at 573-751-2896.

For MHD coverage information, including fees and restrictions, please reference the MHD Fee Schedule at: <http://dss.mo.gov/mhd/providers/pages/cptagree.htm>. Select the provider link, fee schedules, read through the License for Use of Physicians' CPT and select "accept"; then follow the directions given on the MHD Price List Search. The fee schedule will not be updated until mid-February after the HCPCS system updates are completed.

2017 LABORATORY CODE CHANGES

MHD will be implementing laboratory code changes based on the CMS published changes, with some coverage variances. For further detailed information, please reference the CMS document entitled, ***Calendar Year (CY) 2017 Clinical Laboratory Fee Schedule (CLFS) Final Determinations*** available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2017-CLFS-Codes-Prelim-Determinations.pdf>.

2017 RADIOLOGY CODE CHANGES

A number of new radiology CPT codes for mammography coding have been approved for implementation in 2017. Radiology procedure codes 77055 (Mammography; unilateral), 77056 (Mammography; bilateral) and 77057 (Screening mammography, bilateral 2-view study of each breast) are being replaced with codes 77065 (Diagnostic mammography including CAD when performed Unilateral), 77066 (Diagnostic mammography including CAD when performed Bilateral) and 77067 (Screening mammography including CAD when performed Bilateral).

Procedure code G0389 (Ultrasound Exam AAA Screen) is being replaced with 76706 (Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm, AAA).

2017 THERAPY CODE CHANGES

CMS has established eight (8) new “always therapy” codes for physical therapy (PT) and occupational therapy (OT) evaluative and re-evaluative services. These codes replace the 4-code set currently in use for reimbursement purposes of PT and OT evaluative and re-evaluative services.

Effective for dates of service on and after January 1, 2017, PT and OT providers will no longer be able to bill MHD using the 4-code set (97001-97004) for evaluative and re-evaluative therapy services. Providers will be required to submit claims using the following eight new codes for reimbursement:

Evaluation Codes

97161	PT EVAL LOW COMPLEX 20 MIN
97162	PT EVAL MOD COMPLEX 30 MIN
97163	PT EVAL HIGH COMPLEX 45 MIN
97165	OT EVAL LOW COMPLEX 30 MIN
97166	OT EVAL MOD COMPLEX 45 MIN
97167	OT EVAL HIGH COMPLEX 60 MIN

Re-evaluation Codes

97164	PT RE-EVAL EST PLAN CARE
97168	OT RE-EVAL EST PLAN CARE

For more information regarding these changes, please see the “MLN Matters” article at:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9782.pdf>

Please note, therapy services are not covered by MHD for adults receiving a limited benefit package. Additional information regarding therapy benefits and limitations is available in Section 13 of the Therapy Manual at:

http://manuals.momed.com/collections/collection_the/print.pdf .

Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at <http://dss.mo.gov/mhd/> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

MO HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient’s MO HealthNet Managed Care health plan. Before delivering a service, please check the patient’s eligibility status by swiping the MO HealthNet card or by calling the Provider Communications Interactive Voice Response (IVR) System at 573-751-2896 and using Option One for the red or white card.

Provider Communications Hotline