New Diagnostic Procedure Codes and Reimbursement

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PRACTICE **POINTS**

- Reimbursement typically is proportional to the relative value unit (RVU), a number representing the value of the work involved and cost of providing a service relative to other services.
- The total RVU consists of the work RVU, practice expense RVU, and malpractice expense RVU.
- The new 2019 biopsy codes reflect the complexity of the sampling technique (ie, whether the biopsy is tangential, punch, or incisional).
- Accurate completion of Relative Value Scale Update Committee surveys sent to practitioners will allow RVUs to be valued appropriately.

With the implementation of the new Medicare Physician Fee Schedule on January 1, 2019, it can be beneficial for all practitioners to grasp an understanding of how reimbursement is determined. With the new Physician Fee Schedule also came new relative value units (RVUs) and new billing codes. Biopsy codes, in particular, were changed to reflect the complexity of the sampling technique (ie, tangential, punch, incisional). In this article, we explain RVUs and how they determine reimbursement. This article also highlights changes and additions to billing codes, specifically for biopsies and telemedicine services.

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As the US population continues to grow and patients become more aware of their health needs, payers are beginning to recognize the benefits of more efficient and cost-effective health care. With the implementation of the new Medicare Physician Fee Schedule on January 1, 2019, some old billing codes were revalued while others were replaced entirely with new codes.[1] The restructuring of the standard biopsy codes now takes the complexity of different sampling techniques into consideration. Furthermore, *Current Procedural Terminology* (*CPT*) Category III tracking codes for some imaging devices (eg, optical coherence tomography) added in 2017 require more data before obtaining a Category I reimbursable code, while codes for other imaging devices such as reflectance confocal microscopy (RCM) remain relatively the same.[2-4] Notably, the majority of the new 2019 telemedicine codes are applicable to dermatology.[2,3] In this article, we discuss the new *CPT* codes for reporting diagnostic procedures, including biopsy, noninvasive imaging, and telemedicine services. We also provide a summary of the national average reimbursement rates for these procedures.

Background on Reimbursement

To better understand how reimbursement works, it is important to know that all billing codes are provided a relative value unit (RVU), a number representing the value of the work involved and cost of providing a service relative to other services.[5] The total RVU consists of the work RVU (wRVU), practice expense RVU (peRVU), and malpractice expense RVU (mRVU). The wRVU represents the time, effort, and complexity involved in performing the service. The peRVU reflects the direct cost of supplies, personnel, and durable equipment involved in providing the service, excluding typical office overhead costs such as rent, utilities, and administrative staff. The mRVU is to cover the cost of malpractice insurance.[5] The peRVU can be further specified as facility versus nonfacility services depending

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on where the service is performed.[6] A facility peRVU is for services completed in a facility such as a hospital, outpatient hospital setting, or nursing home. The facility provides some of the involved supplies, personnel, and equipment for which they can recapture costs by separate reporting, resulting in a lower total RVU for the provider charges compared with nonfacility locations where the physician must provide these items.[6] Many physicians may not be aware of how critical their role is in determining their own reimbursement rates by understanding RVUs and properly filling out Relative Value Scale Update Committee (RUC) surveys. If surveys sent to practitioners are accurately completed, RVUs have the potential to be fairly valued; however, if respondents are unaware of all of the components that are inherent to a procedure, they may end up minimizing the effort or time involved, which would skew the results and hurt those who perform the procedure. Rather than inputting appropriate preoperative and postoperative service times, many respondents often put 0s and 1s throughout the survey, which misrepresents the amount of time involved for a procedure. For example, inputting a preoperative time as 0 or 1 minute may severely underestimate the work involved for a procedure if the true preoperative time is 5 minutes. Such survey responses affect whether or not RVUs are valued appropriately.

The billing codes and their RVUs as well as Medicare payment values in your area can be found on the Centers for Medicare & Medicaid Services website.[2,3] Table 1 provides a comparison of the old and new biopsy codes, and Table 2 shows the new RCM codes.

Biopsy Codes

Prior to 2019, biopsies were reimbursed using *CPT* code 11100 for the initial biopsy and 11101 for each additional biopsy.[2] Called up for refinement in the RUC process, initial data from the Physician Practice Expense Information Survey pointed to the likelihood of different sampling techniques having different amounts of work being supplied by different techniques.[1] Imaging modalities such as dermoscopy or RCM could help minimize the need for surgical biopsies. Dermoscopy, which has been proven to allow for more efficient and accurate diagnoses in dermatology, is reimbursed in Europe but not in the United States.[7-9] In 2016, *CPT* codes 96931 through 96936 were created for RCM and are covered by most insurances.[10] Optical coherence tomography, another noninvasive imaging technology, currently is not reimbursed but did receive Category III codes (0470T–0471T), also known as a tracking codes, in 2017.[4] Category III codes are used for emerging technologies that have future potential but do not have enough US-based evidence to support receiving Category I *CPT* codes. The use of Category III codes allows for data collection on emerging technologies and services, with the potential to convert the Category III codes to Category I codes once certain criteria are met.[11]

Beginning in 2019, the standard biopsy codes 11100 and 11101 were replaced with 6 new codes to represent

TABLE 1. Comparison of 2018 vs 2019 Biopsy Billing Codes[3]

Billing Code	Description	wRVU	NF-NMA, $	F-NMA, $
2018 codes				
11100	Biopsy of skin, subcutaneous tissue, and/or mucous membrane (including simple closure), single lesion	0.81	108.00	50.76
+11101	Each separate/additional lesion biopsied	0.41	33.48	25.92
2019 codes				
11102	Tangential biopsy, single lesion[a]	0.66	100.91	41.08
11103	Tangential biopsy, each additional lesion[a]	0.38	54.42	23.79
11104	Punch biopsy (including simple closure when performed), single lesion	0.83	126.86	51.54
11105	Punch biopsy, each additional lesion	0.45	62.35	28.11
11106	Incisional biopsy (including simple closure when performed), single lesion[b]	1.01	153.53	62.71
11107	Incisional biopsy, each additional lesion[b]	0.54	75.52	33.52

Abbreviations: wRVU, work relative value unit; NF-NMA, nonfacility national Medicare average; F-NMA, facility national Medicare average.
[a]Includes shave, scoop, saucerization, and curette biopsies.
[b]Includes wedge biopsies.

primary (11102, 11104, 11106) and add-on biopsies (11103, 11105, 11107) based on the sampling technique utilized and the thickness of the sample (Table 1). Previously, the biopsy codes did not reflect the complexity of the different biopsy techniques, whereas the new codes provide differentiation of the method of removal (ie, tangential, punch, incisional).[2,3] The base code is dependent on whichever biopsy performed has the highest complexity, with incisional biopsy—a partial excision—being considered the most complex.[3] Punch biopsy is considered the next level of complexity, followed by tangential biopsy. Each of the 6 new biopsy codes also received a new wRVU, which determines reimbursement under Medicare and most other insurers when combined with direct peRVU and mRVU. Additional biopsies, reported using the add-on codes, are reimbursed at a lower level than the base codes because of removal of duplicate inputs for preservice and postservice care.[3]

Telehealth Codes

Telemedicine services offer another form of imaging that providers can use to communicate remotely with patients through a live interactive video stream (with audio), a store-and-forward system with photographs or videos shared asynchronously, or remote patient monitoring.[12] Although live video streaming uses a webcam, store-and-forward services involve sending photographs or videos electronically for later evaluation.[12,13] Remote patient monitoring allows the collection of health-related data and transmission to a physician without the need for an office visit.[13] Most states require physicians to have a license in the state in which the patient is located at the time of the encounter. Given the difficulty of applying for licensure in multiple states, several states started creating their own special licenses to allow out-of-state providers to offer services through telemedicine.[14] The Federation of State Medical Boards then created the Interstate Medical Licensure Compact (IMLC) for an expedited process to apply for medical licensure in other states. The IMLC was formed to increase access to health care in underserved or rural areas including but not limited to the use of telemedicine.[15] To qualify for IMLC, a physician must have a medical license in a state registered with the IMLC (ie, state of principal license) and have at least one of the following in their state of principal license: primary residence, 25% of their medical practice, a current employer, or US federal income taxes filed.[15] The remaining states that do not have a licensing process for telemedicine allow practice in contiguous states or may provide temporary licenses dependent on the situation.[14]

Since 2017, billing codes for telemedicine have been the same as those used for in-person evaluation and

TABLE 2. 2019 Revisions to the RCM Billing Codes[3]

2019 Billing Code	Description	wRVU	NF-NMA, $	F-NMA, $
96931	RCM; image acquisition, interpretation, and report, first lesion	0.80	173.35	173.35
96932	RCM; image acquisition only, first lesion	0.00	126.50	126.50
96933	RCM; interpretation and report only, first lesion	0.80	47.57	47.57
96934	RCM; image acquisition, interpretation, and report, each additional lesion[a]	0.76	98.75	98.75
96935	RCM; image acquisition only, each additional lesion[a]	0	45.41	45.41
96936	RCM; interpretation and report only, each additional lesion[a]	0.76	45.41	45.41

Abbreviations: RCM, reflectance confocal microscopy; wRVU, work relative value unit; NF-NMA, nonfacility national Medicare average; F-NMA, facility national Medicare average.
[a]List separately in addition to code for primary procedure.

TABLE 3. 2019 Revisions to the Telemedicine Billing Codes[3]

2019 Billing Code	Description	wRVU	NF-NMA, $	F-NMA, $
G2010	Analysis of image/video from an established patient	0.18	12.61	9.37
G2012	Virtual check-in of an established patient	0.25	14.78	13.33

Abbreviations: wRVU, work relative value unit; NF-NMA, nonfacility national Medicare average; F-NMA, facility national Medicare average.

management services with modifiers -95 or GQ added to the end of the code. Modifier -95 has been used for real-time telemedicine services, while modifier GQ has been used for store-and-forward services.[16] For example, the code 99201, which is used to bill for new patients at outpatient visits, would become 99201-95 if performed using a live audio and video feed or 99201-GQ if information was sent electronically for later analysis. To receive reimbursement from Medicare, modifier −95 requires real-time communication using both audio and video; however, modifier GQ is only reimbursable in federal telemedicine demonstration programs in Alaska or Hawaii.[12] Note that reimbursement is up to the discretion of private providers, and even Medicare reimbursement can vary from state to state.

In 2019, new Healthcare Common Procedure Coding System telemedicine codes were introduced to include virtual check-ins (G2012) and evaluation of patient-transmitted images and videos (G2010). G2010 is the first store-and-forward code that has the potential to be reimbursed outside of Alaska or Hawaii.[3,12] G2012 allows providers to monitor the patients' well-being outside of the office setting, a cost-effective alternative if patients do not require a full visit. More detailed descriptions of the new codes can be found in Table 3.[1]

Final Thoughts

As insurance providers continue to better monitor health care costs, it is of utmost importance that physicians become more involved in accurately assessing their services and procedures, given that the changes in RVUs mirror the Centers for Medicare & Medicaid Services' utilization of the RUC's interpretation of our survey responses.[1] The current billing codes attempt to better represent the work involved for each service, one example being the modification to more specific biopsy codes in 2019.

With the growth of technology, *CPT* and Healthcare Common Procedure Coding System codes also reflect a push toward more efficient health care delivery and broader coverage for provider services, as demonstrated by the introduction of new telemedicine codes as well as recent additions of noninvasive imaging codes. Although technology makes health care more cost-effective for patients, clinicians can still maintain their overall reimbursements by efficiently seeing an increasing number of patients; for example, a patient diagnosed noninvasively using RCM can then receive same-day care, which impacts patients' quality of life by minimizing travel time, number of office visits, and time taken off from work, while allowing providers to manage a higher patient volume more productively. The new *CPT* codes discussed here reflect the growth of medical technology potential, which increases our diagnostic capability, making it even more critical for physicians to engage with these developments.

REFERENCES

1. Centers for Medicare & Medicaid Services. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program—Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions From the Medicare Shared Savings Program— Accountable Care Organizations—Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder Under the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. *Fed Registr.* 2018;83(226):59452-60303. To be codified at 42 CFR §405, 410, 411, 414, 415, 425, and 495.
2. Centers for Medicare & Medicaid Services. CY 2018 PFS Final Rule Addenda. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2018-PFS-FR-Addenda.zip. Published 2018. Accessed March 28, 2019.
3. Overview: Medicare Physician Fee Schedule. Centers for Medicare & Medicaid Services website. https://www.cms.gov/apps/physician-fee-schedule/overview.aspx. Accessed March 28, 2019.
4. Medicare Learning Network. July 2017 update of the hospital outpatient prospective payment system (OPPS). Centers for Medicare & Medicaid Services website. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10122.pdf. Published 2017. Accessed March 21, 2019.
5. Medicare Learning Network. Medicare Physician Fee Schedule. Centers for Medicare & Medicaid Services website. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medcrephysfeeschedfctsht.pdf. Published February 2017. Accessed March 19, 2019.
6. Medicare Learning Network. How to use the searchable Medicare Physician Fee Schedule (MPFS). Centers for Medicare & Medicaid Services website. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/How_to_MPFS_Booklet_ICN901344.pdf. Published September 2017. Accessed March 19, 2019.
7. Fox GN. Dermoscopy: an invaluable tool for evaluating skin lesions. *Am Fam Physician*. 2008;78:704, 706.
8. Soyer HP, Argenziano G, Talamini R, et al. Is dermoscopy useful for the diagnosis of melanoma? *Arch Dermatol*. 2001; 137:1361-1363.
9. Kornek T, Schäfer I, Reusch M, et al. Routine skin cancer screening in Germany: four years of experience from the dermatologists' perspective. *Dermatology*. 2012;225:289-293.
10. American Academy of Dermatology Association. New CPT coding updates for 2016. *Derm Coding Consult.* 2015;19:1-2. https://www.aad.org/File Library/Main navigation/Member resources and programs/Publications/DCC/DCC_Winter_2015.pdf. Published 2014. Accessed March 21, 2019.
11. American Medical Association. *CPT* Category III codes. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/physicians/cpt/cpt-category3-codes-long-descriptors.pdf. Updated July 26, 2018. Accessed March 21, 2019.
12. Medicare Learning Network. Telehealth services. Centers for Medicare & Medicaid Services website. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf. Accessed March 19, 2019.
13. Final policy, payment, and quality provisions in the Medicare Physician Fee Schedule for calendar year 2018. Centers for Medicare & Medicaid Services website. https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-medicare-physician-fee-schedule-calendar-year-2018. Published November 2, 2017. Accessed March 19, 2019.
14. *State Telehealth Laws & Reimbursement Policies.* Sacramento, CA: Center for Connected Health Policy; 2018. https://www.cchpca.org/sites/default/files/2018-10/CCHP_50_State_Report_Fall_2018.pdf. Accessed March 19, 2019.
15. The IMLC. Interstate Medical Licensure Compact website. https://imlcc.org/. Accessed March 19, 2019.
16. *Current Procedural Terminology 2018, Professional Edition.* Chicago, IL: American Medical Association; 2018.