

# CPT 2006:

## Another Year, Another Round of Updates



**The E/M codes for consultations and nursing facility visits reflect some of this year's significant changes.**

Cindy Hughes, CPC

It happens every new year. Medical practices begin receiving denials for codes that have been paid for years. Practice revenue is delayed, and valuable employee time is lost. Only then do many practices stop to learn the latest CPT code changes.

It doesn't have to be this way. Now is the time to pause, review the 2006 changes and update your superbill and billing system. This article hits the highlights of the 2006 CPT code changes. A summary of the changes most

likely to affect family physicians is available online at <http://www.aafp.org/fpm/20060100/28cpt2.html>.

### **Evaluation and management codes**

Many changes have been made this year to the evaluation and management (E/M) codes.

The description of modifier -25 has been expanded to further describe significant, separately identifiable

# The description of modifier -25 has been expanded to further describe significant, separately identifiable services.

services. It now explains: “A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see E/M services guidelines for instructions on determining level of E/M service).”


The AMA’s CPT Editorial Panel deleted the follow-up inpatient consultation codes and the confirmatory consultation codes that were billed for consultations requested by patients. Both were found to be redundant. New instructions in the introduction to the consultations codes section in CPT state that only one initial consultation should be provided by a physician per episode of care. The instructions also tell physicians to use subsequent hospital care codes to report services provided after the initial consultation. Consultations requested by the patient or their family should be billed with the appropriate office/outpatient visit codes or inpatient consultation codes.

Codes for care of patients in nursing facilities have undergone a major revision. Codes 99301-99303 and 99311-99313 have been deleted. New initial nursing facility codes 99304-99306 describe only the required key components and problem severity, which makes them consistent in structure with initial hospital care codes. Subsequent nursing facility care should be reported with new codes 99307-99310. Nursing facility discharge codes were not changed. A new code, 99318, for reporting nursing facility assessments has been added under other nursing facility services.

The CPT panel also made major changes in the domiciliary, rest home (e.g., boarding home) or custodial care services codes. Codes 99321-99323 and 99331-99333 have been deleted. Five new codes have been introduced for report-

ing new patient services: 99324-99328. These are comparable in structure to the codes for new patient office visits. New codes have also been added for four levels of established patient visits: 99334-99337. Most notable in this section are new codes 99339 and 99340, which are to be used for reporting care plan oversight provided to a patient who is not under the care of a home health agency, enrolled in a hospice or residing in a nursing facility. These two new time-based codes allow a physician to bill for complex and multidisciplinary care-plan development or revision, such as care given to chronically ill children in their home or to Alzheimer’s patients in an assisted living facility.

## Vaccine coding

The CPT panel has adopted a protocol for assigning CPT codes to vaccines that have completed phase III clinical trials but that haven’t received FDA approval. This protocol will make CPT codes available when the vaccines are approved or shortly thereafter. Previously, the new codes were held up by the limitations of publication deadlines and the time involved in getting the CPT panel’s approval for a new CPT code. These new vaccine codes will have a  symbol before the code listing to indicate that the vaccine is pending FDA approval. The AMA will remove the symbol when the vaccine is approved. The new vaccine codes are released to the AMA Category I Vaccine Codes Web site (<http://www.ama-assn.org/ama/pub/category/10902.html>) each January and July.

Vaccine codes to look for in 2006 include those for a human papilloma virus vaccine, a zoster vaccine and a rotavirus vaccine. Code 90714, which previously was used for a vaccine discontinued in 1999, is now used for preservative-free tetanus and diphtheria toxoids (Td) adsorbed. The existing Td vaccine code, 90718, will remain in use until manufacturers phase out the preservative-containing vaccine. Finally, you should be aware that

■ The 2006 CPT update includes significant code changes for family physicians.

■ The CPT panel deleted the follow-up inpatient consultation codes and the confirmatory consultation codes.

■ Major revisions were made to the codes for care of patients in a nursing facility.

### About the Author

Cindy Hughes is the coding and compliance specialist for the AAFP and is a contributing editor for *Family Practice Management*. Conflicts of interest: none reported.

## INJECTION CODE CHANGES

Here are the old and new CPT codes for therapeutic, prophylactic and diagnostic injections and infusions.

2005	90782	90783	90784	90788	90799
2006	90772	90773	90774	90772	90779

code 90713, poliovirus vaccine, was revised to include intramuscular administration.

### Injections and infusions

One of the mandates of the Medicare Modernization Act was that codes related to injections and infusions be revised. As a result, a new subsection has been added to the CPT manual's Medicine section. The hydration, therapeutic, prophylactic and diagnostic injections and infusions subsection comprises two codes for hydration; five codes for therapeutic, prophylactic and diagnostic injections (see "Injection code changes," above); and four codes for infusions. Codes in the chemotherapy administration subsection also have been revised.

Two sets of instructions in this subsection are significant for family physicians. One reminds physicians to bill significant, separately identifiable E/M services with modifier -25 attached to the E/M code. Another, related to code 90772, "Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular," could cause some confusion. The instructions say to use code 99211 rather than 90772 when the injection is given "without direct physician supervision." Because the incident-to guidelines require direct physician supervision of services billed with 99211, physicians have no means of billing a 90772-type injection given without direct physician supervision if the payer follows the incident-to guidelines.

### Other codes of note

Other CPT 2006 changes include revision of glycosylated hemoglobin code 83036 to refer to "glycosylated (A1C)" and a new code, 83037, for reporting glycosylated (A1C) testing by a device cleared by the FDA for home use. Code 83037 will allow physicians to provide and report the new self-contained system used in a

patient encounter to have real-time A1C results for use in face-to-face patient interaction.

Fecal occult blood test codes have been expanded to reflect the amount of physician work involved in specimen collection. Code 82270 should be used to report three specimens collected by the patient. Code 82271 is used to report a specimen collected by other sources (previously reported with 82273.) Code 82272 is used to report a single specimen, such as that collected from a digital rectal examination.

Special services codes 99050-99060 have been revised to report more accurately services provided after hours or on an emergency basis. Code 99051 has been added for reporting services provided during regularly scheduled evening, weekend or holiday office hours. These codes might enable you to collect some additional revenue; check with your payers to find out whether they provide reimbursement for these codes.

The pediatric and neonatal intensive care codes guidelines have been revised to include codes 36400, 36405 and 36406 in the list of bundled services.

### Codes for performance measurement

Many physicians might not be familiar with optional Category II codes, which were designed to facilitate data collection for performance measurement and introduced in 2004. Appendix H of the CPT manual contains information on the codes and the performance measures they were created to track. At the AAFP's request, the CPT panel has added two modifiers to the Category II codes, -1P and -2P, to indicate services for which performance is measured but that weren't delivered because they were either contraindicated or refused. Incorporating the Category II codes into your practice now will give you a head start toward preparing your practice for any pay-for-performance programs you get involved with in the future.

### Happy coding

Given the significant number of changes in both the E/M and Medicine sections of CPT 2006, you should thoroughly review the changes with your current coding practices in mind. May your new year be full of clear and correct coding and prompt and fair reimbursement. **FPM**

Send comments to [fpmedit@aafp.org](mailto:fpmedit@aafp.org).

The poliovirus vaccine code was revised to include intramuscular administration.

A new subsection of codes related to injections and infusions has been added to CPT's Medicine section.

The special services codes were revised for services provided during regular evening, weekend or holiday office hours.