



RING IN THE NEW DECADE WITH THESE NEW CODES

The changes take effect Jan. 1.

Cindy Hughes, CPC

Like most things in health care, the CPT coding system is always changing to keep up with new services and procedures. This year's changes reflect just that: new codes for new ways of doing things. Not all of the changes will affect you, so we're highlighting here only those that family physicians need to know.

New and revised codes for services that require equipment

Let's start with some good news: Getting paid for services that have traditionally required complex or expensive equipment or are most often provided by subspecialists should be easier with the introduction of new and revised codes for reporting these services. However, the good news comes with a caution: These codes reflect a significant change in health care delivery and, as such, payment for them may be subject to coverage determination decisions by local payers and Medicare carriers. Payers may establish specific guidelines that must be followed when providing these services (for example, some payer policies allow payment of nerve conduction studies only when an electromyography is also performed). Before investing in equipment necessary to provide the following services, check with your common payers to determine if their plans provide coverage:

- 95905 Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/

velocity study, each limb, includes F-wave study when performed, with interpretation and report;

- 0203T Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone) and sleep time;
- 0204T Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation and respiratory analysis (e.g., by airflow or peripheral arterial tone);
- 95806 Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow and respiratory effort (e.g., thoracoabdominal movement).

You should note that HCPCS code S3905 can be reported for the services now described by code 95905 (motor and/or sensory nerve conduction), and HCPCS codes G0398-G0400 are also used to report unattended home sleep testing of Medicare beneficiaries, the service now described by code 95806.

Other notable new codes and revised descriptors

Luckily, not all of the changes in 2010 are as complex as those just described. Several of this year's changes are minor but are still worth noting.

Nursing facility care. The descriptions of codes 99304-99310 and 99318 for reporting nursing facility care have changed to include time spent on the patient's unit or floor. Previously, these codes only included

physician/patient face-to-face time. Now these codes recognize the time physicians spend on chart review, documentation and communication with the patient's family. Remember that time spent *off* the patient's floor is considered pre- or post-service work and is not included in floor time.

Venous wounds. New code 29581 finally provides an easy way to report the application of multi-layer venous wound compression system. This new code allows for differentiation from the single-layer Unna boot.

Injectables. The description of code 90378 for respiratory syncytial virus prophylaxis now indicates that it is for reporting a recombinant monoclonal antibody rather than an immune globulin. Also, code 90379 has been deleted because the product the code represented is no longer available.

Vaccines. Code 90669 for the pneumococ-

cal conjugate vaccine now indicates that it is used to report a 7-valent pneumococcal conjugate vaccine. New code 90670 should be used to report the 13-valent version. The 13-valent product is marked in the CPT book with the \mathcal{N} symbol, which indicates that it is pending FDA approval.

administered to children 2 to 15 months of age, for intramuscular use), which is pending FDA approval. And finally, you should note that the code descriptors for some vaccines and toxoids now include age and "preservative free" designations. These are not intended to reflect a product's licensed indication but rather to assist in differentiating between similar products and services. Of course appropriateness of a vaccine for an individual should be determined by the product's prescribing information and clinical judgment, and not by CPT descriptors.

Changes to consultation codes

The consultation codes in this year's CPT manual are unchanged from last year, but the Centers for Medicare & Medicaid Services

■ Make a note of the new codes for services that require complex or expensive equipment.

■ Be sure to review the changes to several vaccine codes this year.

■ CMS has eliminated the consultation codes from its physician fee schedule for 2010.

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New code 90644 is not listed in this year's CPT manual but will be effective on Jan. 1. This code can be used to report the new Hib-MenCY-TT vaccine (combination meningococcal conjugate vaccine, serogroups C and Y, and hemophilus influenza-b vaccine, tetanus toxoid conjugate, four-dose schedule, when

(CMS) has eliminated these codes from the Medicare Physician Fee Schedule for 2010. For consultations provided to Medicare patients in the outpatient setting, physicians should report new or established patient visit codes, and codes for initial hospital care or initial nursing facility care should be used instead of consultation codes for those sites of service. CMS will also create a new modifier to identify an admitting physician's charge for initial hospital care. Private payers have not yet stated how they will react to this change.

Because family physicians tend to use the consultation codes infrequently and CMS is shifting some of the payment value from the consultation codes to the E/M codes that will be used in place of them, most family physicians will not lose revenue as a result of this change, and some may experience a slight increase. Look for more on this change in *FPM's* "Getting Paid"

About the Author

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Article Web Address: <http://www.aafp.org/fpm/2010/0100/p13>

blog at <http://blogs.aafp.org/fpm/gettingpaid>. We'll post updates there about the new modifier and any further instructions from CMS as soon as we receive them.

Code resequencing

CPT has created a new way to boggle your mind (as if the coding part wasn't hard enough). It is called resequencing: the new process for handling the addition of a code for which no sequential code number is available. The new codes that appear out of numerical order are preceded by the # symbol. In addition, a note appears where each code would have appeared if it were in numerical order. This can be confusing, so here's an example to help.

There are new codes, guidelines and revisions for reporting the excision of soft tissue and bone tumors this year. Unfortunately, code numbers weren't available in the section of CPT where they were needed. To allow for the new codes without renumbering the entire section of codes between 21550-21632, CPT 2010 lists the new codes as follows:

21550 Biopsy, soft tissue of neck or thorax
21552 ▶ Code is out of numerical sequence. See 21550-21632 ◀

21554 ▶ Code is out of numerical sequence. See 21550-21632 ◀

▲ 21555 Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm

#● 21552 3 cm or greater

▲ 21556 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (e.g., intramuscular); less than 5 cm

#● 21554 5 cm or greater

Appendix N in the CPT manual lists all of the codes that have been resequenced.

Here's to 2010

This completes the CPT coding update for 2010. CPT is an ever-changing system, but we'll do our best to keep you up-to-date and informed. I hope this helps you begin the new year with coding clarity, confidence and robust reimbursement! **FPM**

Send comments to fpmedit@aafp.org.

■ Visit the "Getting Paid" blog for the latest coding updates.

■ You'll find resequencing, the process for handling the addition of a code for which no sequential code number is available, in this year's CPT manual.

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