



Changes include new codes for pediatric vaccine administration and subsequent hospital observation care.

CINDY HUGHES, CPC

# CPT Update for 2011: Immunizations, Observations and More

**E**ach new year brings new and revised CPT codes for services you likely have been providing for years. This year is no exception. To ensure your practice is billing correctly and getting paid, make note of the following changes.

## Pediatric vaccination administration codes

CPT 2011 brings significant changes to the pediatric vaccine administration codes, in part to better handle the reporting of combination vaccines. The value of combination vaccines, which can reduce the number of shots required and thus increase vaccination rates, is well known. However, because of the time and effort necessary to counsel parents and caregivers about each vaccine component, practices have always had a backwards incentive to provide individual vaccines, rather than combination vaccines, so they could report multiple administration services to recover their costs – until now. To address this, CPT 2011 replaces codes 90465-90468 with two new codes:

- 90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component,
- +90461 Each additional vaccine/toxoid component. (List separately in addition to code for primary procedure.)

The new administration codes should be reported per vaccine/toxoid component. CPT defines “component” as each antigen in a vaccine that prevents disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple vaccine components. (See a list of common pediatric vaccines and their components on page 7.)

It is important to recognize what the codes do and do not include. First, these codes are limited to immunization administration, meaning the vaccines must be separately reported. Additionally, a face-to-face service with counseling is required. In the absence of counseling, the administrations must be reported with codes 90471-90474. The new codes are reported for administration to patients *through the age of 18*. (No, that’s not a typo. ➤

The age limit has been raised.) Code 90460 should be reported for each separate administration of single-component vaccines or for the first component of a combination vaccine, while code 90461 should be reported for each additional component of a combination vaccine (no modifier 51 required). The route of administration does not matter.

Here's a coding example. An 11-year-old girl presents for a preventive visit (99393). The child and her mother are counseled by the physician on risks and benefits of HPV, Tdap and seasonal influenza vaccines, and the mother signs a consent form. A nurse prepares and administers each vaccine, completes chart documentation and vaccine registry entries, and verifies there is no immediate adverse reaction. Codes reported include 90649 and 90460 for the HPV vaccine and administration; 90715, 90460 and 90461 (2 units) for the Tdap vaccine and its administration; and 90660 and 90460 for the influenza vaccine and its administration. That's five administration codes to report the administration of three vaccine products. However, the reporting is simplified because the route of administration does not affect the code selected and the first component for each vaccine is reported with 90460 regardless of the number of first components reported on a given date.

The child in our example should return to the practice for additional doses of the HPV vaccine. If physician counseling is not provided when the second and third doses are given, code 90460 should not be reported. Instead code 90471 would be appropriate.

Though Medicare will not be your typical payer for these services, the Centers for Medicare & Medicaid Services (CMS) did assign relative value units (RVUs) to the new codes by cross-walking the RVUs of the adult immunization administration codes 90471 and 90472 to the new codes 90460 and 90461. This should encourage payment for administration of each additional component of a pediatric combination vaccine (90461) at

the same rate as the administration of a second individual vaccine (90471).

### Vaccine codes

Several new vaccine codes and code clarifications are also worth noting:

Added to CPT 2011 is code 90644 for the yet-to-be-FDA-approved Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza b vaccine, tetanus toxoid conjugate (Hib-MenCY-TT). Note that this will be a two-component vaccine. It protects infants against diseases caused by hemophilus influenza and meningococcal organisms only using the tetanus toxoid as a conjugate.

The code developed for the H1N1 pandemic vaccine (90663) is included in CPT 2011 but has no utility at this time as there is no longer a separate H1N1 pandemic vaccine formulation. Instead, H1N1 is now one of three strains in the seasonal flu vaccine, which is reported with codes 90655-90660. Likewise, new codes 90664, 90666, 90667 and 90668 were developed in case of any future need for pandemic influenza vaccines.

### Hospital observation codes

Many physicians and coders have been in a quandary over which codes to use for reporting subsequent visits to patients in observation status on dates between the admission and discharge. This has become increasingly common as patients are assigned to observation status for longer periods because of Medicare admission criteria and hospitals needing to avoid penalties for readmissions. In response, CPT has added three subsequent observation care codes: 99224-99226. Key components and typical times for these new codes mirror those for the subsequent hospital care codes (99231-99233).

These new codes are listed out of sequence in CPT between codes 99220 and 99221. As with any evaluation and management service (E/M) provided on the same date as initial

### About the Author

Cindy Hughes is the AAFP's coding and compliance specialist and is a contributing editor to *Family Practice Management*. Author disclosure: nothing to disclose.



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hospital care, the subsequent observation codes should not be reported if the physician later provides initial hospital care on the same date.

Medicare has not yet said whether these new codes may be reported by physicians other than the physician supervising the observation stay. CPT does allow that for subsequent hospital care but not for initial observation care.

### Time-based codes

CPT codes that may be selected based on time spent providing the service underwent an extensive review for 2011. In general, time is defined as face-to-face time with the patient. Look for specific instructions for reporting time in the introductory language of code subsections and in code descriptors and parenthetical instructions.

The introduction to CPT 2011 clarifies that a unit of time is attained when the midpoint is passed. For example, you can report an hour when 31 minutes have elapsed. Note, however, that although CPT allows rounding to the closest time code, this rule should *not* be applied to Medicare billing. CMS considers the typical times listed in CPT to be minimum thresholds and says, "The time approximation must meet or exceed the typical/average time of a specific CPT code billed and shall not be

'rounded' to the next higher level."

For continuous services that last more than one day, time does not reset at midnight. However, any disruption in the service does create a new initial service. CPT gives the following examples: IV hydration given from 11 p.m. to 2 a.m. would warrant codes 96360 (for the initial 31 minutes to one hour) and 96361 x 2 (for each additional hour), but IV push medication given at 10 p.m. and 2 a.m. would warrant 96374 x 2 (single or initial substance/drug) because it is not a continuous service.

For E/M services, when counseling and/or coordination of care occupies more than 50 percent of an encounter (face-to-face time in the office or other outpatient setting, or floor/unit time in the hospital or nursing facility), then time *will* be considered the key or controlling factor to qualify for a particular level of E/M service. In the past, coding such encounters on the basis of time was optional.

Three new codes have been added for reporting inpatient observation services that occur between the admission and discharge.

CPT clarifies that rounding to the closest time code is acceptable; however, this rule does not apply to Medicare.

### Maternity care codes

Changes to the instructions for reporting maternity care include a new definition of postpartum-care-only services (59430). These services include office or other outpatient visits following vaginal or cesarean-section delivery. This aligns with further instructions

## NUMBER OF COMPONENTS IN COMMON PEDIATRIC VACCINES

Number of components	One	Two	Three	Four	Five
Vaccine administration code(s)	90460	90460, 90461	90460, 90461 x 2	90460, 90461 x 3	90460, 90461 x 4
Vaccine	Hepatitis A (HepA) Hepatitis B (HepB) Human Papilloma virus (HPV) Inactivated poliovirus (IPV) Influenza virus Meningococcal conjugate vaccine (MCV) Pneumococcal conjugate vaccine (PCV) Rotavirus (RV) Varicella virus	Hemophilus influenza type B-hepatitis B (Hib-HepB)	Diphtheria-tetanus-pertussis (DTaP) Measles-mumps-rubella (MMR) Tetanus-diphtheria-pertussis (Tdap)	Measles-mumps-rubella-varicella (MMR-V)	Diphtheria-tetanus-pertussis, hepatitis B, inactivated poliovirus (DTaP-HepB-IPV) Diphtheria-tetanus-pertussis, Hemophilus influenza type B, inactivated poliovirus (DTaP-Hib-IPV)

## Although CPT allows rounding time spent to the closest time code, this rule should not be applied to Medicare billing.

New instructions for the global maternity package should simplify coding when services are provided by more than one physician or group.

To address confusion regarding incisions, excisions and debridement, CPT includes a number of changes to skin procedure codes.

The Medicare Physician Fee Schedule also includes changes related to skin procedures. For example, codes for repair of superficial wounds now have a zero-day global period.

regarding the global maternity package:

- Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy or forceps) or cesarean delivery.
- When reporting delivery-only services (59409, 59514, 59612 or 59620), report inpatient post-delivery management and discharge services using E/M codes.
- Delivery and postpartum services (59410, 59515, 59614 or 59622) include delivery services and all inpatient and outpatient postpartum services.
- Medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the Medicine and E/M Services sections in addition to codes for maternity care.

These new instructions should help simplify coding when the global maternity package is not delivered by one physician or physicians of the same group practice.

### Skin procedure codes

When coding for incisions, excisions and debridement, physicians and coders have often wondered whether they should select codes from the Integumentary, Musculoskeletal or Medicine sections of CPT. There has also been some confusion regarding debridement codes and correct reporting by level of tissue removed and method of debridement.

To clear this up, CPT issued a few changes:

- Code 20000 has been deleted. Report 10060 or 10061 for cutaneous and subcutaneous incision and drainage procedures.
- Code 20005 has been revised to indicate incision and drainage of abscess involving the soft tissue below the deep fascia.
- Codes 11040 and 11041 have been deleted. To report debridement of epidermis or dermis only, use the active-wound-care-management codes, 97597 and 97598.
- Debridement of burns is reported with codes 16020-16030.

• Codes 11042-11044 should be reported for debridement based on the deepest level of tissue removed and the size of the surface area of the wound. When reporting debridement of multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths.

• Use modifier 59 to indicate the reporting of debridement of different wounds at different depths (e.g., codes 11043 and 11042-59).

• Codes 11045-11047 are add-on codes to indicate each additional 20 square centimeters or part thereof. A modifier to indicate multiple services is unnecessary when reporting these codes in addition to 11042-11044.

• Do not report debridement codes in conjunction with active-wound-care-management codes for services related to the same wound.

Some changes to the billing and coding of skin procedures are not reflected in CPT but come from the Medicare Physician Fee Schedule. Codes 12001-12018 for repair of superficial wounds will have a zero-day global period in 2011. This means that medically necessary follow-up visits for these services are separately reportable. Remember that for services with a zero- or 10-day global period, the decision to perform a minor surgical procedure is included in the payment for the procedure and should not be reported separately. However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25 appended to the E/M code.

### Some things never change

That's most of the code changes relevant to family medicine this year. While this promises to be a year full of changes that go beyond CPT, you can count on a couple of things to continue: The AAFP will proactively participate in the CPT process, and *FPM* will do its best to answer any questions you have about coding, billing and documentation. **FPM**

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