

CPT 2012

UPDATED & CLARIFIED

It's mostly small changes this year,
but small changes can trip you up too.



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It's here again. With the ringing in of the new year comes the annual update to CPT. The good news for family medicine is that the update brings more clarifications and minor changes than new or significantly changed codes. Here are the changes most likely to affect family medicine practices:

Observation codes. Codes 99218-99220 for initial observation care are not new, but typical times have been added for each code: 30 minutes for 99218, 50 minutes for 99219, and 70 minutes for 99220. These times are important not only when physicians base their billing on time spent counseling or coordinating care but also when they need to calculate prolonged service times.

CPT 2012 also provides clarification regarding the reporting of unit/floor time for inpatient prolonged service codes 99356-99357: The total time includes direct, face-to-face patient contact plus non-face-to-face services provided on the patient's floor or unit in the hospital or nursing facility during the same session. The revised descriptor in CPT indicates that codes 99356-99357 should be used to report prolonged services in both inpatient and observation stays. Medicare contractors probably won't allow reporting of inpatient prolonged service codes for observation services, however,

since they are classified as outpatient services under the Medicare program.

Vaccines and administration. In an attempt to clarify the intent of the pediatric vaccine administration codes 90460-90461, CPT 2012 further defines a vaccine component: *Component* refers to all antigens in a vaccine that prevent disease caused by one organism. Multivalent antigens or multiple serotypes of antigens against a single organism are considered a single component.

The descriptors for codes 90460-90461 were also changed to indicate that billing is allowed for each component of each vaccine or toxoid administered. This change was necessary because some payers misinterpreted the slash in the previous 90460 descriptor ("first vaccine/toxoid component") to mean that they needed to pay for only one unit of 90460 per date regardless of the number of vaccines or toxoids administered. You may still see this with some payers, but the CPT Editorial Panel's intent is clear: 90460 should be separately reported for the counseling and administration services related to the first or only component of each vaccine or toxoid administered, with 90461 for each additional component. (This will not change the Vaccines for Children Program, since federal regulations limit payment

for vaccine administration to a single payment per vaccine and not per component.)

Other vaccine code changes include deletion of code 90470 for H1N1 immunization administration and 90663 for the pandemic formulation of the H1N1 vaccine. Codes 90664 and 90666-90668 remain active should another pandemic flu vaccine be needed. The descriptor for code 90581, anthrax vaccine, now includes intramuscular use to conform to current vaccine delivery. Code 90654 should be used for a split virus, preservative-free influenza vaccine for intradermal administration.

Developmental testing. The descriptors for developmental testing codes were changed to differentiate explicitly between screening and diagnostic testing. Code 96110 is now described as “Developmental screening, with interpretation and report, per standardized instrument form.” Code 96111 is now described as developmental testing that includes “assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments” with interpretation and report.

Laboratory. When testing for HIV-1 antigen with HIV-1 and HIV-2 antibodies on a platform yielding a single result, report new code 87389. Add modifier 92 when the test is performed with a kit or transportable instrument that wholly or in part consists of a single-use, disposable analytical chamber. This modifier is also applicable to antibody testing represented by codes 86701, HIV-1 only; 86702, HIV-2 only; and 86703, HIV-1 and HIV-2 test yielding a single result when performed with a single-use, disposable analytical chamber.

Radiology. A complete lumbosacral spine study including bending views is now defined as a minimum of six views and should be reported with code 72114. For a study with bending views only, two or three views are required, and the service should be reported with code 72120. Studies without bending views may still be reported with codes 72100 for two or three views and 72110 for a minimum of four views.

Contraceptive capsules. Due to changes in contraceptive products, codes 11975, “Insertion, implantable contraceptive capsules,” and 11977, “Removal with reinsertion, implantable contraceptive capsules,” have been deleted. Code 11976 for removal of an implantable

contraceptive capsule is still valid and may be reported with 11981 when an implanted contraceptive capsule is removed and replaced with a non-biodegradable drug delivery implant on the same date.

Compression systems. Three new codes have been added for application of multi-layer compression systems according to the site of application. The codes are expanded beyond application for treatment of venous wounds of the lower extremity to include treatment of postmastectomy edema of the upper extremity. The codes are as follows for the specified sites:

- 29581: leg (below knee), including ankle and foot,
- 29582: thigh and leg, including ankle and foot, when performed,
- 29583: upper arm and forearm,
- 29584: upper arm, forearm, hand, and fingers.

These codes should not be reported in conjunction with strapping (29540), Unna boot (29580), endovenous ablation (36475-36478), or manual lymphatic drainage (97140). Report only the comprehensive code for the extremity treated (e.g., do not report 29581 and 29582 on the same date).

Bone density measurement. Deleted in 2012 are codes 77079, “Computed tomography, bone mineral density study, 1 or more sites, appendicular skeleton” and 77083, “Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), 1 or more sites.” Codes 77078, “Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)” and 77080-77082 for dual energy x-ray absorptiometry are unchanged.

Preventive services. In response to the mandated health plan coverage of certain preventive services under the Affordable Care Act, a new modifier has been added to CPT. When you provide a service that is not specifically identified as preventive, but you’re providing it as a preventive service based on an A or B rating by the U.S. Preventive Services Task Force or on legislative mandates, append modifier 33 to clarify the preventive nature of the service. Staff should be aware of local payment policies for preventive services, which might include use of this modifier to identify otherwise diagnostic services that are ordered as a preventive service. The modifier may not be required by payers who prefer to identify preventive services by the diagnosis code on the claim.

That’s it. As I said above, 2012 brings more clarifications and instructional changes than new or revised codes. Let’s hope that family medicine fares as well in all that the new year brings! 

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