

# CPT Update for

# 2013

This year's changes include some promising new codes for care coordination.

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**E**very year as the weather begins to cool and the leaves begin to turn, the American Medical Association and its Current Procedural Terminology (CPT) Editorial Panel disseminate changes to the CPT code set. For 2013, the addition of codes for complex chronic care management and transitional care management is perhaps the most significant change for family medicine (see “Complex chronic care coordination and transitional care management codes,” page 9). Appendix B in the CPT manual includes a summary of the approximately 600 changes. This article focuses on those few most likely to affect family physicians.

**Vaccine codes.** Two new influenza vaccine codes were added for 2013. As this issue goes to press, 90653, “Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use,” is still pending approval by the U.S. Food and Drug Administration (FDA). Code 90672, “Influenza virus vaccine, quadrivalent, live, for intranasal use,” has been approved. Vaccine code 90739 for Hepatitis B is also new: “Hepatitis B vaccine, adult dosage (two dose schedule), for intramuscular use.” It is pending FDA approval as well. Make sure you confirm FDA approvals before you use the pending codes. In addition, 90718, “Tetanus and diphtheria toxoids (Td) adsorbed when administered to individuals seven years or older, for intramuscular use,” was deleted. Use 90714, which includes the words “preservative-free,” for any Td vaccine you administer.

**Radiology codes.** CPT has changed the descriptors for “Radiologic examination, spine, cervical” codes to better clarify the number of views. Use 72040 for three views or less, 72050 for four to five views, and 72052 for six or more views.

**Psychiatric codes.** New codes 90791, “Psychiatric diagnostic evaluation,” and 90792, “Psychiatric diag-

nostic evaluation with medical services,” are to be used for diagnostic assessment or reassessment. These services do not include psychotherapeutic services. The two new codes replace the diagnostic interview exam codes 90801 and 90802, which have been deleted. The section of CPT devoted to psychiatric codes includes quite a few additional changes. If you bill these codes in your practice, you should carefully review Appendix B in the 2013 manual before submitting any claims in January.

**Allergy testing codes.** Code 95010, for percutaneous tests, and 95015, for intracutaneous tests, have been replaced by the following new codes:

- 95017, “Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests,”
- 95018, “Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests.”

Code 95075 has been replaced by the following:

- 95076, “Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug, or other substance); initial 120 minutes of testing,”
- 95079, “... each additional 60 minutes of testing (list separately in addition to code for primary procedure).”

**Other changes of note.** CPT 2013 has updated descriptions throughout the manual to be more inclusive of nonphysician providers, described as “qualified health care professionals.” For instance, the phrase “physician supervision” has been replaced with simply “supervision” in the descriptions of codes 99374-99379 for patients in hospice, home health, and nursing facilities. **FPM**

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## COMPLEX CHRONIC CARE COORDINATION AND TRANSITIONAL CARE MANAGEMENT CODES

CPT 2013 includes several new codes designed to capture some of the coordination of care services you and your clinical staff provide between visits. Although the Centers for Medicare & Medicaid Services (CMS) has not yet indicated that it will pay for these new codes, their inclusion in CPT is an important first step toward payment for this otherwise uncompensated work that many family physicians do every day. Many anticipate that CMS will eventually assign values to these codes and that other payers will follow suit.

**Complex chronic care coordination.** These new codes are for reporting time devoted to complex chronic care coordination by physicians, other qualified health care professionals, and clinical staff that totals at least 31 minutes during the course of one month. The total minutes must be documented and should not include time spent on the date of the first visit or on a day when the physician or qualified health care professional reports an E/M service. Care coordination activities may include the following:

- Communication (with the patient, family members, guardian or caretaker, surrogate decision makers, or other professionals) regarding aspects of care,
- Communication with home health agencies and other community services utilized by the patient,
- Collection of health outcomes data and registry documentation,
- Patient, family, or caretaker education to support self-management, independent living, and activities of daily living,
- Assessment and support for treatment regimen adherence and medication management,
- Identification of available community and health resources,
- Facilitation of access to care and services needed by the patient or family,
- Development and maintenance of a comprehensive care plan.

Here are the descriptors for the new codes. Note that the "first hour" is not a threshold. CPT direct physicians to bill 99487 or 99488 for the first 31 to 74 minutes of care coordination services and 99489 for each additional 30 minutes:

- 99487, "Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month,"

- 99488, "... first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month,"
- 99489, "... each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)."

**Transitional care management.** These new codes are for reporting care provided by physicians or other qualified health care professionals or licensed clinical staff under their direction to established patients during a transition from an inpatient setting to a community setting (home, domiciliary, rest home, or assisted living).

Code 99495 represents transitional care management services involving at least moderate complexity decision making, with a face-to-face visit within 14 calendar days of discharge. Code 99496 represents transitional care management services involving high complexity decision making, with a face-to-face visit within seven calendar days of discharge. Both codes require communication with the patient or caregiver within two business days of discharge by direct contact, telephone, or electronic means. Transitional care management codes may be submitted once per patient within 30 days of discharge.

Non-face-to-face transitional care management provided by the physician or other qualified health care professional may include the following, according to CPT:

- Obtaining and reviewing the discharge information,
- Reviewing the need for or following up on pending diagnostic tests and treatments,
- Interacting with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems,
- Educating the patient, family, guardian, or caregiver,
- Establishing or re-establishing referrals and arranging for needed community resources,
- Assisting in scheduling any required follow-up with community providers and services.

Examples listed for non-face-to-face services provided by clinical staff are the same as for complex chronic care coordination (see above), with the exception of collection of health outcomes data and registry documentation and development and maintenance of a comprehensive care plan.