

CPT UPDATE FOR

2014

Changes this year include revisions to transitional care management codes and new interprofessional consultation codes.

This is the season for the annual updates to CPT! Yes, it is the time of year when the American Medical Association's CPT Editorial Panel makes changes to the CPT code set. For 2014, here are some of the changes most likely to affect family physicians.

Transitional care management (TCM) codes. Several revisions were made to the CPT guidelines for codes 99495 and 99496 in order to align them with Medicare rules. The 2014 CPT manual formalizes a change that was made in February 2013 to allow TCM services to be reported for established *and* new patients. In addition, the 2014 guidelines make explicit that additional evaluation and management (E/M) services may not be reported separately if they are provided on the same date as the first face-to-face TCM visit. They must be provided on subsequent dates to be reimbursed. Also, the discharge service does not constitute the face-to-face visit that the TCM codes require. Finally, the guidelines clarify that the same individual should not report TCM services provided in the postoperative period of a service that the individual reported, which also makes it clear

that you may report TCM in the postoperative period if you did not perform the operative service.

Interprofessional telephone/Internet consultation codes. New codes 99446-99449 are time-based codes and should be used by family physicians when their advice is sought by another specialist who is treating the patient. The codes cover provider-to-provider telephone or Internet consultations for the diagnosis and/or management of a patient's problem when a face-to-face consultation with the patient is not necessary. These codes can be used for new or established patients. One example could be an urgent and complex situation in which a face-to-face service is not possible because of location.

The treating physician may not bill for the consultation. His or her work is considered to be included in the E/M code he or she bills when seeing the patient; the interprofessional telephone or Internet discussion is not separately reportable by the treating physician. However, the treating physician may report prolonged service codes 99354-99357 if the patient is present and accessible to the treating physician and the total time of the visit and consultation is 30 minutes more than the typical time,

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as defined by CPT, of the E/M service performed. If the patient is *not* present and the discussion time is 30 minutes more than the typical time of the appropriate E/M service performed, report prolonged service codes 99358-99359.

The following are descriptors of the new codes:

- 99446, “Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review,”
- 99447, “11-20 minutes of medical consultative discussion and review,”
- 99448, “21-30 minutes of medical consultative discussion and review,”
- 99449, “31 minutes or more of medical consultative discussion and review.”

It is important to note that these codes cannot be reported when the physician has agreed to accept a transfer of care prior to the telephone or Internet assessment.

Complex chronic care coordination codes. Revisions were made to the guidelines for complex chronic care coordination codes 99487-99489. First, it’s important to note that in its final rule the Centers for Medicare & Medicaid Services (CMS) has stated its intent to not pay for complex chronic care management services until 2015; CMS currently considers them to be “bundled” services. The changes to the codes in CPT are intended to facilitate Medicare payment in 2015, so 2014 is a good time to get familiar with the codes and the changes that have been made in the CPT guidelines for reporting them. It is still unclear whether many private payers will accept these codes in the interim.

These codes are intended for use only for those patients who require complex care coordination in the management of chronic health issues. According to CPT, an example of an adult patient who requires this type of care is “a patient who has one or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.” This could be a patient with dementia, chronic obstructive pulmonary disease, and diabetes

who requires coordination of health and support services from multiple subspecialties and other community service agencies. The care coordination plan is to be contained in the medical record of the patient at the care coordination office or medical practice of the physician facilitating the care, which is typically the patient’s primary care physician. Changes for 2014 are as follows:

- The definition was expanded from “implementing” a care plan to “developing, substantially revising, and implementing” a care plan under the direction of a physician or other qualified health professional,
- Details were added to assist in determining when to use these codes. For instance, the guidelines now include examples of when a substantial change has occurred in the care plan, such as identifying a new problem that requires additional interventions,
- The guidelines detail what a comprehensive plan should typically include, such as a problem list, expected outcome and prognosis, measurable treatment goals, symptom management, etc.
- The new guidelines clarify that these codes cannot be reported if the care plan is unchanged or requires minimal changes, such as only a change in the patient’s medication,
- The guidelines elaborate on how to report the time of clinical staff with this explanation: “Only the time of the clinical staff of the reporting professional is counted. Only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient.”

Because these codes are primarily distinguished based on the clinical staff time involved, it is important to understand the role of clinical staff as directed by the physician when using these codes. According to CPT, the staff role includes care coordination activities such as the following:

- Medication management,
- Ongoing patient education,
- Patient self-management,
- Outreach services.

In addition to providing details regarding care coordination performed by clinical staff, the guidelines also outline in detail all the capabilities an office or practice must have as it relates to care coordination:

- Provide 24/7 access to physicians or other qualified health providers or clinical staff,

■ CMS will not pay for complex chronic care management services until 2015.

■ Care coordination plans should be contained in the patient’s medical record at the care coordination office, which is typically the primary care physician’s office.

■ The new guidelines clarify that complex chronic care codes cannot be reported if the care plan is unchanged or requires minimal changes.

Several revisions were made to the guidelines for codes 99495 and 99496 to align with Medicare rules.

- Use a standardized methodology to identify patients who require this service,
- Have an internal care coordination process or function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner,
- Use a form and format in the medical record that is standardized within the practice,
- Be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

Cerumen removal. Code 69210 for impacted cerumen removal has been changed from a bilateral code to a unilateral code, effective Jan. 1, 2014. For a bilateral procedure, report 69210 with modifier 50. The American Academy of Otolaryngology–Head and Neck Surgery further defines cerumen as clinically “impacted” if any one or more of the following are present:

- Visual considerations: Cerumen impairs the exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition,
- Qualitative considerations: Extremely hard, dry, irritative cerumen is causing symptoms such as pain, itching, or hearing loss,
- Inflammatory considerations: Cerumen is associated with foul odor, infection, or dermatitis,
- Quantitative considerations: Obstructive, copious cerumen cannot be removed without magnification and multiple instrumentations requiring physician skills.

You should only use code 69210 when removal of the impacted cerumen requires instrumentation, such as a curette, forceps, and/or suction. Code 69210 should not be coded when impacted cerumen is removed by irrigation only, or when the cerumen accumulation does not meet the definition of impacted cerumen. When impacted cerumen is removed by irrigation only, or the cerumen is not impacted, that service is included in the

E/M code and is not separately reportable.

Vaccine codes. There are five new vaccine codes, 90685-90688, for new quadrivalent influenza vaccines that include coverage of two Type A and two Type B strains. These vaccines include an additional Type B strain when compared to the trivalent vaccine. They should be administered intramuscularly and are based on the patient’s age. Descriptors are as follows:

- 90673, “Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use,”
- 90685, “Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use,”
- 90686, “Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use,”
- 90687, “Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use” (pending approval by the U.S. Food and Drug Administration),
- 90688, “Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use.”

It should be noted that these are just a sample of the changes to CPT for 2014. For a full list of changes, consult Appendix B in your 2014 CPT book and examine the codes you use most frequently in your practice. Keep in mind that not all payers will reimburse for the services and codes listed. Please check with your payers for specific coverage and payment information. **FPM**

■ Cerumen removal code 69210 has been changed from a bilateral code to a unilateral code.

■ This code should only be used when removal requires instrumentation.

■ Five new influenza vaccine codes that include coverage of two Type A and two Type B strains.

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