THIS YEAR'S NEW CODES COVER EVALUATIONS DONE OVER THE PHONE OR ONLINE.

CPT 2008: A Glimpse of the Future of Family Medicine?

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This year's CPT update won't dramatically affect the way you code the services you provide in face-to-face visits. However, it does recognize new ways of delivering health care services. The addition of codes for telephone and online evaluations reflect a reality anticipated in the Future of Family Medicine report – one in which "interactions will not be limited to traditional, individual, face-to-face encounters between the patient and the family physician."[1] Time will tell whether health insurers share this same vision; at press time, it was unclear whether any of the major plans would provide reimbursement for the services these codes represent.

A table summarizing these and other changes most likely to affect family physicians is available online at http://www.aafp.org/fpm/20080100/cptchanges2008.pdf.

Telephone and online services

The CPT Editorial Panel and the CPT Advisory Committee spent a good deal of time in recent months defining codes for telephone calls and online evaluations. The new codes assign pre- and post-work periods to each service.

Telephone services codes should be used by a physician to report episodes of care initiated by an established patient (someone who has received face-to-face services from you or another physician of the same specialty in your group in the past three years) or by the patient's guardian:

- 99441 Telephone evaluation and management (E/M) service provided by a physician to an established patient, parent or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion;
- 99442 Same as 99441 except call includes 11-20 minutes of medical discussion;
- 99443 Same as 99441 except call includes 21-30 minutes of medical discussion.

These new codes come with several caveats:

1. Telephone services that are reported with 99441, 99442 or 99443 must be personally performed by the physician.
2. If the telephone service relates to and takes place within the postoperative period of a procedure provided by the physician, the service is considered part of the procedure and should not be separately reported.
3. Telephone services should not be reported when the same services are reported as care plan oversight or anticoagulation management (codes 99339-99340, 99374-99380 or 99363-99364).
4. When a telephone service refers to an E/M service performed and reported by the physician within the previous seven days, it is not separately reportable, regardless of whether it is the result of patient-initiated or physician-requested follow-up.

Online medical evaluations should now be reported with code 99444, which replaces deleted code 0074T.

NOW WE MUST AWAIT WORD FROM PAYERS ON WHAT PAYMENT POLICIES THEY WILL IMPLEMENT FOR ALL OF THESE NEW AND REVISED CODES.

The full description of code 99444 includes limitations similar to those for the new telephone service codes:

• 99444 Online E/M service provided by a physician to an established patient, guardian or health care provider not originating from a related E/M service provided within the previous seven days, using the Internet or similar electronic communications network.

Please note some additional caveats related to online E/M services:

1. Reportable services must involve the physician's personal, timely response to the patient's inquiry.

2. If the online service relates to and takes place within the postoperative period of a procedure provided by the physician, the service is considered part of the procedure and not separately reported.

3. Online services should not be reported when the same services are reported as care plan oversight or anticoagulation management (codes 99339-99340, 99374-99380 or 99363-99364).

4. When an online service refers to an E/M service performed and reported by the physician within the previous seven days, it is not separately reportable, regardless of whether it is the result of patient-initiated or physician-requested follow-up.

5. The service should be reported only once for the same episode of care in a seven-day period and includes all other communications stemming from the online encounter (e.g., follow-up telephone calls, prescription provision, and lab and imaging orders).

6. Either electronic or hard-copy documentation of the encounter must be permanently stored.

About the Author

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

Tobacco, alcohol and substance-abuse counseling

New codes 99406 and 99407 were created to encourage physicians to provide and report tobacco cessation counseling. They replace codes G0375 and G0376. Code 99406 should be used to report a counseling visit lasting longer than 3 minutes and up to 10 minutes. Code 99407 should be used to report intensive counseling that takes more than 10 minutes. See "An Update on Tobacco Cessation Reimbursement," *FPM*, May 2006, for more on reporting these services.

Physicians can also report structured screenings and brief interventions for alcohol or substance abuse (other than tobacco) with new codes 99408 (for services that take 15 to 30 minutes) and 99409 (for services that take longer than 30 minutes). The structured screening should use a screening tool such as the AUDIT (Alcohol Use Disorders Identification Test) or the DAST (Drug Abuse Screening Test). Information on the screening tools and brief interventions can be found on the World Health Organization Web site at http://www.who.int/substance_abuse/activities/sbi and on the Project Cork Web site at http://www.projectcork.org/clinical_tools. Unfortunately, these two codes – 99408 and 99409 – are not covered in the Medicare fee schedule.

Other changes of note

Here are a few more CPT changes for 2008 that might affect your coding:

Time-based billing. Time-based billing is now an option for nursing home visits when more than 50 percent of the physician's face-to-face time with the patient is spent in counseling or coordination of care. Typical

The CPT changes for 2008 took effect Jan. 1.

This year's update includes new codes for nontraditional encounters.

It's not clear whether any major health insurers will pay for phone or online services, despite the new codes.

times (which are listed on the summary of this year's changes available online at http://www.aafp.org/fpm/20080100/cptchanges2008.pdf) have been assigned to nursing home services codes 99304-99310 and 99318.

Medical team conferences. New codes 99366, 99367 and 99368 take the place of codes 99361 and 99362, which have been deleted. Code 99366 should be reported by qualified health care professionals who spend 30 minutes or longer in a team conference with the patient or the patient's family. When physicians participate in team conferences with the patient or the patient's family, E/M codes appropriate to the setting (e.g., home services codes 99347-99350) should be reported rather than code 99366. Remember, when reporting E/M services where coordination of care and counseling are the predominant services, the level of service may be chosen based on time.

Two codes were added to report tobacco cessation counseling.

Different codes must be used when reporting team conferences at which neither the patient nor the patient's family is present. Code 99367 should be reported by a physician who spends 30 minutes or longer in a team conference without the patient or the patient's family present. Note that the time begins with a review of the patient's case and ends with conclusion of the review. Time related to record keeping or report generation should not be included. Code 99368 should be reported if a qualified health care professional spends 30 minutes or longer in the same scenario as code 99367.

Time-based billing is now an option for some nursing home visits.

Ocular photoscreening. Ocular photoscreening (a technique involving the comparison of photos taken when light directed through one undilated pupil is reflected by the ocular fundus of both eyes simultaneously) of small children for conditions such as strabismus and amblyopia will no longer be reported with code 0065T. New code 99174 now represents bilateral ocular photoscreening with interpretation and report. It should not be reported with visual function screening (99172) or a screening test of visual acuity (99173).

Care of ill infants. The CPT 2008 update includes a new E/M code for initial care of an infant:

The changes include a new E/M code for initial care of an infant who is not critically ill or injured but does require some intensive care services.

- 99477 Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who is not critically ill or injured but requires intensive observation, frequent interventions and other intensive care services.

Services reported with code 99477 are not critical care but are of higher severity than those reported with code 99223 for initial hospital care. Proponents of the new code noted that conditions might include but are not limited to respiratory distress, infection, hyperbilirubinemia, dehydration, anemia, asphyxia and metabolic disorders. These neonatal intensive care services encompass medical, cardiac and surgical conditions and diseases. Services might include enteral and parenteral nutritional maintenance, metabolic and hematologic maintenance, and pharmacologic control of the circulatory system.

Services for ill neonates who do not require intensive observation, frequent interventions and other intensive care services should continue to be reported with codes 99221-99223. The codes for initial care of the normal newborn (99431) and of the critically ill neonate (99295) are unchanged.

Potential new vaccines

As in previous years, CPT has assigned codes to vaccines that are awaiting FDA approval. Three such vaccines are listed in CPT 2008 with the lightning bolt symbol (⚡), which indicates that FDA approval was pending at the time of publication:

- 90661 Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use;
- 90662 Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use;
- 90663 Influenza virus vaccine, pandemic formulation. (This might be something to note in your practice's pandemic influenza plan.)

In addition, three other vaccine codes for products pending FDA approval will be implemented on Jan. 1, 2008, but will not be published until CPT 2009:

- 90650 HPV vaccine, types 16 and 18, bivalent, three-dose schedule for intramuscular use;
- 90681 Rotavirus vaccine, human, attenuated, two-dose schedule, live, for oral use;
- 90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered

to children 4 years through 6 years of age, for intramuscular use.

The AMA will remove the lightning bolt symbol from these codes when they receive FDA approval. Any changes that take effect before the next manual is published can be found online at http://www.ama-assn.org/ama/pub/category/10902.html.

Clarified modifiers

CPT 2008 also provides new descriptions for some modifiers in Appendix A. The changes are designed to resolve confusion about who may use the descriptors and how they should be reported. The new descriptors are intended to indicate the following about modifiers 25 and 59:

- These modifiers are not specific to a health care professional but focus on the services provided.
- To report a significant, separately identifiable E/M service with a non-E/M service performed on the same date, append modifier 25 to the E/M code.
- Modifier 59 should not be appended to an E/M service.
- Modifier 59 indicates that a procedure or service was distinct or independent from other non-E/M services.

The more things change ...

As usual, now we must await word from payers on what payment policies they will implement for all of these new and revised codes. However, the decision by the CPT Editorial Panel, which includes payer representatives, to add these well-defined codes for non-face-to-face service offers hope for new reimbursement opportunities. I hope this finds you looking forward to another year in family medicine and the exciting possibilities for the future. FPM

Send comments to **fpmedit@aafp.org.**

1. Future of Family Medicine Project Leadership Committee. The future of family medicine: a collaborative project of the family medicine community. *Ann Fam Med.* 2004;2(suppl):3-32. Available at: http://www.annfammed.org/content/vol2/suppl_1. Accessed Nov. 6, 2007.

- The updated version of CPT includes codes for three versions of the influenza virus vaccine that are awaiting FDA approval.
- Appendix A of CPT 2008 includes revised descriptors for some modifiers, including 25 and 59, in an attempt to reduce recurring errors in how they are reported.