California Academy of Family Physicians
Strategies for Coding, Billing & Getting Paid Appropriately
2009 Supplement
New Year; New Codes; New Billing Opportunities

The new year brings additional CPT codes as well as enhanced billing opportunities for family physicians. This supplement provides an update of revisions to CPT, ICD-9, Medicare payment, and other changes family physicians should be aware of. Additionally, there may be:

- New deductible amounts to be collected from patients;
- New and/or revised billing requirements from health insurance plans; and
- New payment rates from third party payers.

Now is the time to review these changes and determine how your practice can capture potential new revenue.

Deductibles:

The Medicare Part B deductible did not increase for 2009; it is still $135. The coinsurance for Part B Medicare remains at 20 percent. It is likely that many practices will see an increase in patient deductibles from various commercial carriers at the beginning of 2009. This is the time of year each practice must take a few extra minutes to verify insurance eligibility and benefits from patients and collect any deductible amounts used, but not met.

CPT Coding Changes:

A total of 519 changes have been made in CPT for 2009. While a total of 291 new codes have been added (150 of them in the CPT Category II codes – performance measurement), there were 134 codes that were revised and 94 codes that were deleted. Remember that a code revision can be just as important as a new or deleted code; these revisions should be reviewed each year as opposed to simply verifying that all codes on your fee schedule are still current.

One of the explanatory revisions important to family physicians is an explanation in the Preventive Medicine Services section which clarifies examples screening tests (vision, hearing and developmental) that may be separately reported in addition to the Preventive Medicine (well-care) Service.

Evaluation and Management Services – Newborn and Pediatrics

There are 17 new E/M service codes for 2009 and they are all in the newborn/pediatric care service area. This entire CPT section has been revised and consolidated to better report services to the newborn and pediatric patient who receive intensive and critical care.

Family physicians who provide newborn care services should take note of the changes as outlined in **Table 1**:

Table 1: Newborn Care

Service Description – Newborn Care	Previous Code	2009 CPT Code
Initial Hospital or birthing center care, per day, for E/M of normal newborn infant	99431	99460
Initial care, per day, for E/M of normal newborn infant seen in other than hospital or birthing center	99432	99461
Subsequent hospital care, per day, for E/M of normal newborn	99433	99462
Initial hospital or birthing center care, per day, for E/M of normal newborn infant admitted and discharged on the same date	99435	99463
Service Description – Delivery/Birthing Room Attendance	**Previous Code**	**2009 CPT Code**
Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn	99436	99464
Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	99440	99465

CPT 99464 (attendance at delivery) may be reported in conjunction with other initial care services (99460 – normal newborn; 99468 – neonate critical care; or 99477 – neonate under intensive observation).

Evaluation and Management Services – Definitions of Commonly Used Terms

An explanatory comment has been added to the Definitions of Commonly Used Terms that clearly states "E/M services may also be reported by other qualified health care professionals who are authorized to perform such services within the scope of their practice." This phrase acknowledges that qualified non-physician professionals (e.g., Physician Assistants, Nurse Practitioners, Registered Nurses, etc.) may perform E/M services as allowed by their licenses.

Family physicians should keep this in mind when utilizing trained staff for such things as chronic disease management and smoking cessation counseling. Remember, however, that plan payment ultimately depends upon whether the plan covers such services or recognizes the particular provider type for payment for E/M services.

Evaluation and Management Services – Prolonged Services Guidelines Changes

Extensive explanations have been added to the E/M Services Prolonged Services subsection to clarify add-on E/M services. Other services (non-E/M) that are prolonged may warrant the use of modifier 22 rather than the use of these CPT Codes (99354 – 99359). The explanations also further clarify that when counseling and coordination of care are not the dominant service (i.e., time is not the basis of E/M code selection), the prolonged service code may still be used. For example, a patient that requires an interpreter may prolong the service 30 minutes or more beyond the typical time.

Family physicians should remember the following question-and-answer exchange which occurred at the 2009 CPT Symposium sponsored by the AMA:

Q: In the instructions for 99356 it states that unit/floor time is used and also that this code is the correct prolonged service code to use with a nursing facility service. Yet, the nursing facility codes refer to typical time with the patient and/or family and do not specify face-to-face. Is it unit time or face-to-face time?

A: It is unit time. Typically the time is spent with the patient and/or family face-to-face, but the intent is to parallel the hospital inpatient codes. When the nursing facility typical times were established by a RUC survey and published in 2008, the typical time was surveyed as unit time.

. . . . . . .Peter A. Hollman, M.D.
AMA CPT Editorial Panel Vice Chair
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Surgical Changes:

For those family physicians that perform or assist in surgical procedures, there are changes to services for hemorrhoid destruction, abdominal wall hernia services, and destruction by a neurolytic agent. Any physician providing these services should review 2009 CPT in detail to determine if you are using the correct codes.

Other Medicine Changes:

There are several new vaccine codes, some of which are already available for use. Others are pending FDA approval. Two that are available for use on 1/1/2009 are:

90681 Rotavirus vaccine, human, attenuated, 2 dose scheduled, live, for oral use
90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine, and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children ages four to six, for intramuscular use

The revision of the entire CPT section on Hydration, Injections and Infusions, and Biologic Agent Administration should affect most family physicians. The placement of this subsection in CPT has been moved and no longer follows the Vaccines and Toxoids section; it now immediately precedes the Chemotherapy Administration section. This means all the injection codes have been deleted and all new CPT codes have been developed. The new codes range from 96360 – 96379.

The most notable change is the deletion of CPT 90772 (therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular) which was replaced with CPT 96372. There is an explanatory comment following this code that clarifies physicians are not to report 96372 for injections given without direct physician supervision. To report those services, CPT 99211 should be used. Here's an example of how you would differentiate the coding of these two services:

Example 1: Patient A comes in to the office for her monthly B_{12} injection. Dr. Smith is in the office seeing other patients and a supervised assistant gives the patient her B_{12} medication. Because Dr. Smith was in the office providing direct physician supervision, the service is billed to Medicare using CPT 96372 to report the administration of the medication.

Example 2: Patient B comes in to the office early one morning to receive her monthly B_{12} injection for her pernicious anemia. Dr. Smith is making rounds at the hospital at this time. RN Jones greets Patient B, verifies it is time for the patient to receive her monthly B_{12} injection and administers the medication subcutaneously. Dr. Smith was not available to provide direct supervision so this service is billed as CPT 99211. Patient B was not a Medicare patient.

Table 2 outlines a complete crosswalk of the new injection codes.

Table 2: Injection Administration Crosswalk

Service Description	2008 Code	2009 Code
Intravenous infusion, hydration; initial, 31 minutes to 1 hour	90760	96360
Intravenous infusion, hydration; ea. add'l hour	90761	96361
IV infusion, for therapy, prophylaxis, or diagnosis; initial up to 1 hour	90765	96365
IV infusion, for therapy, prophylaxis, or diagnosis; ea. add'l hour	90766	96366
IV infusion, for therapy, prophylaxis, or diagnosis; add'l sequential infusion, up to 1 hour	90767	96367
IV infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion	90768	96368
Subcutaneous infusion for therapy or prophylaxis; initial, up to 1 hr, including pump set-up and establishment of subcutaneous infusion site(s)	90769	96369
Subcutaneous infusion for therapy or prophylaxis; ea. add'l hour	90770	96370
Subcutaneous infusion for therapy or prophylaxis; add'l pump set-up with establishment of new subcutaneous infusion site(s)	90771	96371
Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular	90772	96372
Therapeutic, prophylactic, or diagnostic injection; intra-arterial	90773	96373
Therapeutic, prophylactic, or diagnostic injection; IV push, single or initial substance/drug	90774	96374
Therapeutic, prophylactic, or diagnostic injection; ea. add'l sequential IV push of new substance/drug	90775	96375
Therapeutic, prophylactic, or diagnostic injection; ea. add'l sequential IV push of same substance/drug provided in facility	90776	96376
Unlisted therapeutic, prophylactic, or diagnostic IV or Intra-arterial injection or infusion	90779	96379

Remember:

As always, not all plans implement the new coding changes immediately. Each practice must wait and see what payment policies insurers will develop and implement. Some will have policies developed by mid-year; others might take as long as a full year.

2009 Medicare Changes:

The Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees Medicare, approved a final rule that will affect many payment policies beginning in 2009. Consider the following final rule changes (see **Table 3** for more information):

- Replaces the previously proposed 15.1 percent cut to Part B services with an overall 1.1 percent payment (effective in 2009).

- Shifted and recalculated the budget-neutrality adjustor. The effect is approximately a 6 percent reduction to the conversion factor and a 12 percent increase to physician work values. The 2009 conversion factor will fall from $38.09 (2008 level) to $36.07. Average payments, however, will increase by 1.1 percent as mandated by the Medicare Improvements for Patient and Providers Act (MIPPA) of 2008.

- The deductible for Part B services remains at $135.

- Eliminates the deductible for the ***Welcome to Medicare*** (initial preventive physical exam or IPPE) and increases the benefit period from the initial six months to an initial 12 months. Additionally, it adds **end-of-life counseling** and body mass index measurement as part of the IPPE. MIPPA removed the electrocardiogram from the list of IPPE mandated services, making it an education, counseling, and referral service to be discussed with the individual and ordered by the physician, if necessary.

Table 3: Examples of Medicare Payment Changes

Area	99203 ('08/'09)	99204 ('08/'09)	99205 ('08/'09)	99213 ('08/'09)	99214 ('08/'09)	99215 ('08/'09)
03	103.94 / 102.40	156.39 / 156.54	195.43 / 196.80	68.77 / 69.00	102.89 / 103.47	137.99 / 138.79
05	113.13 / 110.73	169.07 / 168.12	210.77 / 210.89	74.81 / 74.57	111.74 / 111.63	149.41 / 149.30
06	113.13 / 110.97	169.07 / 168.67	210.77 / 211.67	74.81 / 74.76	111.74 / 111.95	149.41 / 149.79
07	105.88/ /104.22	159.32 / 159.23	199.08 / 200.18	70.07 / 70.19	104.84 / 105.25	140.59 / 141.19
09	110.87 / 105.83	166.48 / 161.94	207.87 / 203.69	73.43 / 71.35	109.77 / 107.02	147.04 / 143.61
17	100.89 / 103.22	152.23 / 157.40	190.46 / 197.85	66.54 / 69.12	99.70 / 103.71	134.01 / 139.25
18	100.62 / 102.90	152.11 / 156.55	190.46 / 196.95	66.25 / 68.55	99.34 / 102.92	133.72 / 138.38
26	102.96 / 103.87	155.10 / 158.39	193.98 / 199.11	67.76 / 69.51	101.52 / 104.31	136.45 / 140.09
99	72.48 / 93.19	140.68 / 143.53	176.47 / 180.99	61.15 / 62.63	81.78 / 94.16	123.73 / 126.80

Areas:	03 = Marin, Napa, Solano	05 = San Francisco
	06 = San Mateo	07 = Alameda/Contra Costa
	09 = Santa Clara	17 = Ventura
	18 = Los Angeles	26 = Orange
	99 = other, North & South	

Other Medicare Bonus Payments:

The 2009 final rule also changed and/or authorized Medicare two bonus programs. The Physician Quality Reporting Initiative (PQRI) and Medicare's e-prescribing bonus program are described in detail below. In this time of declining payment, it essential for practices to explore all ways of increasing revenue. Taking advantage of some of the bonus payment opportunities is a good way to do just that. By successfully participating in both PQRI reporting and the e-prescribing initiative, you could potentially increase Medicare payment by a total of 4 percent. That, coupled with the 1.1 percent increase in the fee schedule, equates to a 5 percent increase for 2009.

PQRI Incentive Program: Increased the Physician Quality Reporting Initiative (PQRI) bonus incentive to 2 percent for 2009 and 2010. The 2009 measures were increased to 153 (from 119 in 2008). Seven measure groups have been established for 2009 as well. A practice may report on a claims basis or through a qualified registry. There is no sign-up or pre-registration required for participation in the 2009 PQRI incentive program. Submission of quality data codes for the 2009 PQRI quality measures to CMS through claims or a qualified registry will indicate the intent to participate in the program

NOW is the time to start reporting these measures to qualify for the 2 percent bonus 9. If you haven't reported before, here are some steps to take to begin to implement the reporting of the PQRI measures:

1) Members of the clinical and billing teams meet with the practice to discuss goals and provide education on PQRI measures;

2) Your practice selects the measures to report - each provider may report as many measures as desired, but must report at least three quality measures;

3) Develop tools and worksheets for data capture; and

4) Monitor the billing process to assure that accurate quality measure data is being reported to Medicare.

To access the quality measures, along with sample worksheets and other tips for reporting the measures, go to: www.cms.hhs.gov/pqri and choose the Measures/Codes link. Family physicians should particularly be interested in the Educational Tool "PQRI Made Simple – Reporting the Preventive Care Measures Group." Access this tool at the above Web site under the Educational Tools link.

It will also be helpful to review the 2007 PQRI Experience Report to assess some of the challenges faced by others who have previously participated. That report is downloadable at:
http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportExperience.pdf

Appendix A of this supplement provides an example of a claim that is accurately billed to Medicare reporting PQRI measures. Three measures are reported [one measure requires two quality data codes for reporting the measure]. Click here to view Appendix A.

E-Prescribing Incentive Program: A five-year program of e-prescribing incentive payments will begin in 2009. Initially, physicians are offered a 2 percent bonus in Medicare payment if you can demonstrate an acceptable level of e-prescribing. This will gradually decrease and will eventually be replaced with a penalty for physicians who have not started to e-prescribe.

To participate, you must use a "qualified" e-prescribing system. There are two types of systems: a system for e-prescribing only (a "stand-alone" system), or an electronic health record (EHR) system with e-prescribing functionality. Either of these systems may be used for the incentive program, as long as they are "qualified." A qualified system must be able to do the following:

1. Generate a complete medication list that incorporates data from pharmacies and benefit managers (if available);
2. Select medications, transmit prescriptions electronically* using the applicable standards and warn the prescriber of possible undesirable or unsafe situations;
3. Provide information on lower-cost, therapeutically-appropriate alternatives (for 2009, tiered formulary information, if available, meets this requirement); and
4. Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan.

** The prescription must be sent electronically. If the network converts the electronic prescription into a fax because the pharmacy can't get electronic faxes, this counts as e-prescribing. If the e-prescribing system is only capable of sending a fax directly from the e-prescribing system to the pharmacy, the system isn't a qualified e-prescribing system. Detailed system requirements are available at www.cms.hhs/gov/pqri. Select "E-prescribing Incentive Program."*

Here are some other resources for exploring e-prescribing options:

E-Health Initiative: "A Physician's Guide to Electronic Prescribing" is a joint effort of the American Medical Association, American Academy of Family Physicians (AAFP), American College of Physicians and Medical Group Management Association. Issued in October 2008, the goal is to help clinicians make informed decisions about how and when to transition from paper to electronic prescribing systems. The report is available at http://www.ehealthinitiative.org/assets/Documents/e-Prescribing_Clinicians_Guide_Final.pdf

Get Rx Connected: A number of major physician organizations, including the AAFP, have launched a Web site to help physicians adopt e-prescribing. The site takes physicians through the steps necessary to successfully switch from paper to electronic-based prescriptions. If you already use an EHR, the Web site can also tell you if your software meets Medicare Part D e-prescribing standards. The website is www.getrxconnected.com.

Surescripts: Founded by the pharmacy industry in 2001, Surescripts creates a secure exchange of prescription information. Guidance on adoption of e-prescribing systems and a list of certified e-prescribing programs is available on their website – www.surescripts.com

Reporting the E-prescribing Incentive Program Measure:

To get the incentive in 2009, you have to report on the e-prescribing quality measure. You can report on the e-prescribing measure with two simple steps:

1. Family physicians should bill one of the following denominator codes:

96150	96151	96152		
99201	99202	99203	99204	99205
99211	99212	99213	99214	99215
99241	99242	99243	99244	99245
G0101	G0108	G0109		

2. Report one of the three G-codes listed below on more than 50 percent of applicable cases for the numerator. One of the G codes must be reported on the same claim as the numerator billing code.

G8443	Used a qualified e-prescribing system for **all** of the prescriptions
G8445	Had a qualified e-prescribing system, **but** didn't generate any prescriptions during this encounter
G8446	Had a qualified e-prescribing system, **but** prescribed narcotics or other controlled substances
G8446	Had a qualified e-prescribing system, **and** state or Federal law required you to phone in or print the prescriptions
G8446	Had a qualified e-prescribing system, **and** the patient asked that you phone in or print the prescriptions
G8446	Had a qualified e-prescribing system, **and** the pharmacy system can't receive electronic transmission

Appendix B provides an example of a claim that is accurately billed to Medicare for e-prescribing. Click here to view Appendix B.

Appendix C provides an example of a claim that is accurately billed to Medicare reporting both PQRI measures and use of e-prescribing. Click here to view Appendix C.