



New Year, New Codes, New Billing Opportunities

The new year brings updated CPT codes as well as additional billing opportunities for family physicians. Now is the time for you and your staff to review coding and documentation changes to determine how best to capture potential new revenue.

As always, not all plans implement coding changes immediately. You should wait and see what policies the plans you contract with will develop and implement for new codes. Some will have policies developed by mid-year; others might take as long as a full year to develop those policies.

CPT Coding Changes:

Evaluation and Management Services – Newborn and Pediatrics

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

Family physicians who provide newborn care services should take note of these changes outlined in Table 1 (below).

Table 1

Service Description – Newborn Care	Previous Code	2009 Code
Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant	99431	99460
Initial care, per day, for E/M of normal newborn infant seen in setting 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 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 is important because it acknowledges that qualified non-physician professionals (e.g., physician assistants, nurse practitioners, RNs, etc.) can both perform and be paid for some E/M services.

Keep this in mind when utilizing your entire team to assist managing your patients with chronic disease and enhancing your efforts with challenges such as smoking cessation. Remember, however, that payment ultimately depends on whether the plan covers such services and/or ensures that the type of provider you are using can be paid for providing that E/M service. Unfortunately, the rules are not consistent across plans and services.

Evaluation and Management Services – Prolonged Services Guidelines Changes

Extensive explanations have been added to the E/M Services Prolonged Services subsection. Prolonged, non-E/M services may warrant the use of modifier 22 rather than the use of these CPT Codes (99354 – 99359). 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 who requires an interpreter may prolong the service 30 minutes or more beyond the typical time.

Keep in mind the following scenario, raised at the 2009 CPT Symposium sponsored by the American Medical Association (AMA), involving prolonged services when seeing patients in a nursing facility:

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.

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Surgical Changes

If you 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 the 2009 CPT in detail to determine if the correct codes are currently being used.

Other Medicine Changes:

A significant change affecting most family physicians are the CPT section revisions on Hydration, Injections and Infusions, and Biologic Agent Administration. This subsection has been moved and no longer follows Vaccines and Toxoids; it now immediately precedes Chemotherapy Administration. 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 for family physicians 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 to differentiate the coding of these two services:

Example 1: Patient A comes in to the office for her monthly B₁₂ injection. Dr. Smith is in the office seeing other patients, and a supervised assistant gives the patient her B₁₂ medication. Because Dr. Smith was in the office providing direct physician supervision, the service is billed to Medicare using CPT 96372 to report medication administration.

Example 2: Patient B comes in to the office early one morning to receive her monthly B₁₂ injection for pernicious anemia. Dr. Smith is still rounding at the hospital. Joe Jones, RN greets Patient B, verifies it that it is the appropriate time to receive her monthly B₁₂ injection and then he 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.

Medicare Changes for 2009

Like CPT, each January there are Medicare changes in coverage and payment that you should also be aware of. The 2009 final rule has a variety of policy changes that significantly affect medical practices. The final rule:

- Replaced the previously proposed 15.1 percent Part B payment cut with an overall 1.1 percent increase.
- Shifted and recalculated the budget-neutrality adjustor. The effect is approximately a six percent reduction to the conversion factor and a 12 percent increase to physician work values. The conversion factor for 2009 will fall from \$38.09 in 2008 to \$36.07. Average payments, however, will increase by 1.1 percent as mandated by the Medicare Improvements for Patient and Providers Action (MIPPA) of 2008. Example payment changes are explained in **Table 2** (below).
- Eliminated the co-payment for the **Welcome to Medicare** Exam (initial preventive physical exam or IPPE) and increases the benefit period from six to 12 months for the beneficiary. Additionally, it adds **end-of-life counseling** as well body mass index measurement as part of the IPPE service. MIPPA removed the electrocardiogram from the list of mandated services that must be included in the IPPE, leaving education, counseling, and referral service to be discussed with the individual and ordered by the physician, if necessary.

Table 2

Area/Year	99203	99204	99205	99213	99214	99215
05 – 2008	113.13	169.07	210.77	74.81	111.74	149.41
05 – 2009	110.73	168.12	210.89	74.57	111.63	149.30
18 – 2008	100.62	152.11	190.46	66.25	99.34	133.72
18 – 2009	102.90	156.55	196.95	68.55	102.92	138.38
99 – 2008	72.48	140.68	176.47	61.15	81.78	123.73
99 - 2009	93.19	143.53	180.99	62.63	94.16	126.80

Area 05 = San Francisco Area 18 = Los Angeles Area 99 = other (North & South)

Other Medicare Bonus Payments:

The 2009 final rule also updates Medicare bonus payment guidelines:

PQRI:

Increases the Physician Quality Reporting Initiative (PQRI) bonus incentive to two percent for 2009 and 2010. The 2009 measures increased to 153 (from 119 measures in 2008).

NOW is the time for you to start reporting these measures to qualify for the 2009 bonus. If you haven't reported before, here are some steps to implement PQRI reporting:

- 1) Schedule a meeting with your clinical and billing teams to discuss goals and provide education on PQRI measures.
- 2) Selects the measures you would like to collect and report on - each provider may report as many measures as desired, but you must report a minimum of three quality measures.
- 3) Develop tools and worksheets to capture the data; some patient registries have been approved to report PQRI measures to Medicare.
- 4) Monitor your billing process to ensure that data is being reported accurately to Medicare.

To access the quality measures, along with sample worksheets and other reporting tips, go to: www.cms.hhs.gov/pqri and choose the Measures/Codes link. It will also be helpful to review the 2007 PQRI experience report to assess the challenges faced by others. That report is downloadable at:

www.cms.hhs.gov/pqri/downloads/prqi2007reportexperience.pdf

E-Prescribing:

The final rule implemented a five-year program of incentive payments for e-prescribing. Initially, a two percent Medicare bonus payment is available in 2009 if you can demonstrate an acceptable level of e-prescribing. Eventually, this will be replaced with a one percent payment decrease for physicians who have not started to e-prescribe by 2012.

You should start to explore options for e-prescribing now. Many practice management systems have the ability to integrate e-prescribing within existing functionality, so first check with your vendor to see what options might be readily available.

Here are some other resources for exploring e-prescribing:

E-Health Initiative: "A Physician's Guide to Electronic Prescribing" is sponsored by the American Medical Association, American Academy of Family Physicians, American College of Physicians and Medical Group Management Association. This 2008 report helps clinicians make informed decisions about how and when to transition from paper to e-prescribing systems. The report may be found at: www.ehealthinitiative.org/erx/clinician.

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

SureScripts: Founded by the pharmaceutical industry in 2001, Surescripts has created a secure system for bidirectional communication between physician offices and pharmacies. Guidance on

adoption of e-prescribing systems and a list of certified e-prescribing programs is available on their website – www.surescripts.com

Summary

In this time of declining payment, particularly in primary care, it is important to explore all ways of increasing practice revenue. Take advantage of the bonus payment opportunities to increase revenue. By successfully participating in both PQRI and the e-prescribing initiative, your practice could potentially increase its Medicare payment by four percent. Coupled with the 1.1 percent fee schedule increases, this could mean total Medicare payment increases of five percent in 2009, not to mention improved office efficiency and clinical outcomes that could result from participation.

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