

Coding Alert

Overview of Code and Billing Changes in 2010

A look ahead into the New Year brings numerous CPT, HCPCS and other Medicare coding and billing changes.

Preparation is essential so your coding is current, effective and compliant

1) Review and update your office encounter form for applicable changes.

An accurate encounter form is essential to ensure you receive the reimbursement to which you are entitled. Who is in charge of updating your encounter form? Be sure everyone has input into the changes, set a time limit for review, approval and finish early. Depending on your specialty, the code changes will vary as to the significance of impact on your practice.

Utilize Appendix B in *CPT@ 2010* for a summary of all CPT code additions, deletions and revisions.

2) Education.

Everyone in the practice should be informed regarding the 2010 code and Medicare changes. CPT code changes for 2010 encompass approximately 423 changes (219 new codes, 141 code revisions and 63 code deletions). Unless otherwise specified, new codes and Medicare changes are effective for services performed on or after January 1, 2010.

Listed below are some key CPT changes that will affect physician practices. Be sure to review *CPT@ 2010* for other applicable changes. Additionally, watch for new information on your Medicare contractor's website and other published bulletins.

Evaluation and Management (E/M) Services

- Revisions to the CPT Guidelines have been made for Consultation Services and the Prolonged Physician Services without Direct (Face-to-Face) Patient Contact subsection. New editorial revisions exist for Nursing Facilities service codes and Delivery/Birthing Room Resuscitation services.

Surgery Services

- Significant changes include the Musculoskeletal System related to excision of subcutaneous soft tissue tumors and radical resection of bone tumor codes (41 new codes, 53 revised codes and 7 deleted codes).
- The most notable changes made in the Digestive System are within the Anus section, particularly the Excision subsection where nearly all of the codes were editorially revised.
- Changes were made in the Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic section to clarify facet joint and facet joint nerve injections.
- Paravertebral facet joint or facet joint nerve injection codes 64470 – 64476 have been deleted and a new subheading was added for Paravertebral Spinal Nerves and Branches. Six new codes were created for reporting paravertebral facet joint injections with image guidance.
- Revisions were made to the Urinary System with the addition of new codes 51727, 51728 and 51729 to allow reporting of combinations of services that are usually provided together for urodynamic studies. Code 51726 is now a parent code used to report the use of complex cystometrograms as an independent service.

Radiology Services

- The most significant revisions to the Radiology section are the addition of a series of codes for CT colonography diagnostic and screening procedures, cardiac magnetic imaging codes and guidelines.
- Category III codes previously used to report cardiac computed tomography (CT) and coronary computed tomographic angiography (CTA) have been deleted and moved to a Category I status. New codes 75571-75574 have been created to report these services.

Pathology and Laboratory Services

- Codes 82306 and 82652 have been revised to clarify reporting Vitamin D and the methodology of testing.
- Code 83987 has been established for laboratory analysis of the pH of exhaled breath condensate, a test used to differentiate gastroesophageal reflux (GER) in asthmatic symptoms.
- Code 84145 has been created to report Procalcitonin (PCT).
- A new code, 84431 is used to report Thromboxane metabolites(s), including thromboxane if performed, urine.

Medicine Services

- A new code has been created in the Vaccines, Toxoids section to report PCV-13 (90670) which when approved by the FDA, will be indicated for active immunization of infants and children for the prevention of invasive pneumococcal disease and otitis media.
- Revisions made in the Special Otorhinolaryngologic Services section includes a new code to report basic vestibular evaluation and clarifies the reporting of vestibular function tests, with recording (e.g., ENG).
- Changes have also been made in the cardiovascular section within the codes related to Implantable and Wearable Cardiac Device Evaluations.

Category II Codes (Tracking Codes for Performance Measurement)

- Category II codes encompass the fastest growing section in the CPT codebook. A total of 98 new codes for quality measurement have been added. Nine new clinical conditions and 46 revised clinical conditions have been made for 2010.

3) Review Medicare's 2010 regulatory changes.

Numerous Medicare changes are effective for services on or after January 1, 2010. Below are just a few of these policy changes. Staff should review other Medicare changes, which may affect your practice.

- The 2010 Medicare Part B deductible is \$155.00 (2009 - \$135.00).
- Two new HCPCS codes were created to report H1N1 services. G9141 for administration and G9142 for the vaccine product. These codes became effective September 1, 2009.
- Medicare has eliminated the use of consultation service codes with the exception of telehealth initial consult codes. Physicians and qualified NPPs will report an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes previously reported. The principal physician of record will append modifier "AI" Principal Physician of Record, to the E/M code when billed. For Medicare operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. Refer to *MLM Matters® Number: MM6740* for additional information on this topic.

4) Update your fee schedule and review the new codes to determine the impact on your practice.

Fee schedules need to be reviewed and updated annually. We recommend an RVU approach to fee setting with individual code comparison to fee schedules of multiple payers.

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The above steps can assist with coding accuracy, claims processing, compliance and revenue optimization. Staying current with the annual CPT, HCPCS and ICD-9-CM codes and Medicare changes is essential in today's healthcare business.

For questions or assistance on coding and billing education and training, please contact our office at (402) 330-2660 and ask for any one of our staff in our health care consulting division.

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