

## **CPT Coding Changes, Implementation of ICD-10, and Medicare Coverage and Fee Schedule Changes for 2009**

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### ***CPT Changes for 2009 – Not All-Inclusive***

One of the changes we can always count on are the updates to the Current *Procedure Terminology* (CPT) codes. Coding changes pertinent to primary care physicians include:

#### New/Revised Vaccines, Toxoid Codes

When FDA approved use the following codes to report:

- 90650 Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule
- 90736 Japanese encephalitis virus vaccine, inactivated

Not to be confused with the existing code 90680 rotavirus vaccine, pentavalent, 3 dose schedule, live for oral use. *CPT 2009* includes a new code 90681 rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use.

More choices to report combination vaccines:

- 90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and polio virus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age
- 90698 Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and polio virus vaccine, inactivated (DTaP-Hib-IPV)

#### New Hydration and Injection Administration Codes Excludes Chemotherapy Administration

Just as you were becoming comfortable with the revisions made to the hydration, infusion, and injection administration codes that changed in *CPT 2007*, the codes (90760-90779) have been deleted and renumbered to be in the 963XX series of codes. Hydration is now reported using 96360 and 96361.

The greatest impact for primary care physicians is the renumbering of 90772 therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular to 96372. This code is effective with dates of service on and after January 1, 2009.

During the past year, Newby Consulting, Inc (NCI) has noted that when billing Medicare and most other insurers, many primary care physicians are failing to append the -25 modifier to the evaluation and management (E/M) code when also reporting the injection administration code. This results in payment denial for the E/M service. When these E/M services are denied, some practices simply stop reporting the administration code instead of investigating the reason for the denial. Physicians can typically append the -25 modifier and refile the claim, but some Medicare contractors are requiring practices to perform a telephone reopening requesting the addition of the -25 modifier in order to be paid for the visit.

#### Newborn Care Services

Also affecting primary care physicians is the renumbering of newborn care services. Codes 99431-99440 have been deleted. To report normal newborn services, physicians should report the following codes

- 99460 Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant

- 99461 Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center
- 99462 Subsequent hospital care, per day, for evaluation and management of normal newborn
- 99463 Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date
- 99464 Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn
- 99465 Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output

Continue to report 99238 or 99239 for newborn hospital discharge services provided on a date subsequent to the admission date. Remember these are time-based codes and time must be documented in the patient's medical record.

#### Neonatal and Pediatric Inpatient Services

New sections have been created in CPT 2009 to report:

- Critical care services for pediatric patient (24 months of age or less) during interfacility transport
- Inpatient neonatal critical care (28 days of age or less)
- Inpatient pediatric critical care (29 days to 24 months of age)
- Inpatient pediatric critical care (2 through 5 years of age)
- Hospital care for neonate (28 days or less) requiring intensive observation, frequent interventions, and other intensive care services

#### ***ICD-10 – Implementation Date October 1, 2013***

After years of discussion, in the January 15, 2009 *Federal Register*, CMS published the final rule modifying the standard medical data code sets. Physicians will transition from *ICD-9-CM* to *ICD-10-CM* on October 1, 2013. Although hospitals will transition both their diagnosis and inpatient hospital procedures from *ICD-9* to *ICD-10*, physicians are only changing diagnosis codes. Physicians will continue to use *CPT* and *HCPCS* codes to report services rendered.

CMS believes this transition

- Incorporates much greater specificity and clinical information, which results in:
  - Improved ability to measure health care services
  - Increased sensitivity when refining grouping and reimbursement methodologies
  - Enhanced ability to conduct public health surveillance
  - Decreased need to include supporting documentation with claims
- Includes updated medical terminology and classification of diseases
- Provides codes to allow comparison of mortality and morbidity data
- Provides better data for:
  - Measuring care furnished to patients
  - Designing payment systems
  - Processing claim
  - Making clinical decisions
  - Tracking public health
  - Identifying fraud and abuse
  - Conducting research

CMS provides the following comparison between *ICD-9-CM* and *ICD-10-CM* in the MLN Matters Number SE0832 (Revised 10-09-08) available on the CMS website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf>

	<i>ICD-9-CM</i>	<i>ICD-10-CM</i>
# of Characters	3-5 Numeric (+V and E codes)	3-7 Alphanumeric
# of Codes	~13,500	~68,000

As shown in the table above, *ICD-10* codes may be longer, and there are about five times as many of them. Consequently, in an unabridged *ICD-9* to *ICD-10* mapping, each *ICD-9* code is typically linked to more than one *ICD-10* code, because each *ICD-10* code is more specific. Below are examples that show where *ICD-10-CM* codes are more precise and provide better information.

<i>ICD 9-CM</i>	<b>Mechanical complication of other vascular device, implant, and graft – 1 code</b>
996.1	Mechanical complication of other vascular device, inpatient and graft

<i>ICD-10-CM</i>	<b>Mechanical complication of other vascular grafts – 156 codes, including</b>
T82.310	Breakdown (mechanical) of aortic (bifurcation) graft (replacement)
T82.311	Breakdown (mechanical) of carotid arterial graft (bypass)
T82.312	Breakdown (mechanical) of femoral arterial graft (bypass)
T82.318	Breakdown (mechanical) of other vascular grafts
T82.319	Breakdown (mechanical) of unspecified vascular grafts
T82.320	Displacement of aortic (bifurcation) graft (replacement)
T82.321	Displacement of femoral arterial graft (bypass)
T82.322	Displacement of femoral arterial graft bypass
T82.328	Displacement of other vascular grafts

<i>ICD-9-CM</i>	<b>Pressure ulcer codes – Total of 9 location codes – Shows broad location, but not depth (stage)</b>
707.00	Pressure ulcer, unspecified site
707.01	Pressure ulcer, elbow
707.02	Pressure ulcer, upper back (shoulder blades)
707.03	Pressure ulcer, lower back (Sacrum)
707.04	Pressure ulcer, hip
707.05	Pressure ulcer, buttock
707.06	Pressure ulcer, ankle
707.07	Pressure ulcer, heel
707.09	Pressure ulcer, other site (e.g., head)

<i>ICD-10-CM</i>	<b>Pressure ulcer codes – 125 codes – Shows more specific location as well as depth, including</b>
L89131	Pressure ulcer of right lower back, stage I
L89132	Pressure ulcer of right lower back, stage II
L89133	Pressure ulcer of right lower back, stage III
L89134	Pressure ulcer of right lower back, stage IV
L89139	Pressure ulcer of right lower back, unspecified stage
L89141	Pressure ulcer of left lower back, stage I
L89142	Pressure ulcer of left lower back, stage II

L89143	Pressure ulcer of left lower back, stage III
L89144	Pressure ulcer of left lower back, stage IV
L89149	Pressure ulcer of left lower back, unspecified stage
L89151	Pressure ulcer of sacral region, stage I
L89152	Pressure ulcer of sacral region, stage II

Although 2013 is almost five (5) years from now, physicians should begin to think about this transition. NCI recommends starting to think about this transition now. If you are still using paper superbills/charge tickets/fee slips, using the examples above you can see how there will be changes in the specificity of your frequent diagnoses. Review the diagnosis codes currently on your superbill,

- are there diagnostic statements infrequently used
- how many unspecified diagnosis codes are you currently reporting
- determine your most frequently reported diagnosis codes

Starting with the diagnosis codes most frequently reported, identify the specificity required for *ICD-10*. These codes are available on the CMS website at [http://www.cms.hhs.gov/ICD10/02m\\_2009\\_ICD\\_10\\_CM.asp#TopOfPage](http://www.cms.hhs.gov/ICD10/02m_2009_ICD_10_CM.asp#TopOfPage)

Compare the specificity of the information to the diagnostic statements on your superbill and, even more importantly, in your progress notes. Coding is the easy part of transitioning to *ICD-10*. We will still use the index looking up the main term and then verify the code selected in the index is the correct code by looking in the tabular list. The fact we may be reporting 7 alphanumeric digits vs 5 numeric/alphanumeric digits is irrelevant. The problem will be having a complete diagnostic statement to code as well as how to modify the superbill to allow for the specificity.

**Medicare Conversion Factor**

Under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), the Centers for Medicare & Medicaid Services (CMS) is required to apply a 1.1 percent update to the 2009 Physician Payment System. Physicians may be confused about how CMS applied a positive update when the 2009 conversion factor (CF) (\$36.0666) is significantly lower than the 2008 conversion factor (\$38.087).

§1848(c)(2)(B)(ii)(II) of the Social Security Act requires that increases or decreases in relative value units (RVUs) for a year may not cause the amount of expenditures for the year to differ by more than \$20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS must make adjustments to preserve budget neutrality (BN).

In CY 2008, CMS met the BN requirement by applying a separate BN adjustment factor (-11.94 percent) to the work RVUs. This is why many services had a lower fee schedule in 2008 even though Congress required a positive 0.5 percent increase. Beginning in CY 2009, §133(b) of the MIPPA requires CMS to apply the required BN adjustment to the conversion factor.

Calculation of the CY 2009 PFS CF	
CY 2008 Conversion Factor	\$38.0870
CY 2009 CF Update 1.1 percent	(1.011)
CY 2009 CF Budget Neutrality Adjustment	0.08 percent (1.0008)
5-Year Review Budget Neutrality Adjustment	-6.41 percent (0.9359)
<b>CY 2009 Conversion Factor</b>	<b>\$36.0666</b>

All of these calculations do result in a positive Medicare fee schedule update, but it does not mean that physicians will see a 1.1 percent increase for all services when comparing the 2009 fee schedule with the 2008 fee schedule. For example, the 2008 Indiana Medicare fee schedule allowance for 99213 (\$56.79) increases to \$58.66 for 2009. The change in calculating the BN adjuster actually results in an increase of 3.29 percent.

Other services that are more heavily weighted to practice expense are expected to decrease due to this calculation. For example, the code for electrocardiogram 93000 will decrease 7.32 percent to \$19.36, down from \$20.89. The code for chest x-ray AP/Lateral views (71020) is down 2.96 percent from \$30.10 to \$29.21 for 2009.

If §131 of the MIPPA had not been enacted, the CY 2009 conversion factor update would have been -15.1 percent. Congress needs to act in 2009 to prevent the -21+ percent conversion factor update for calendar year 2010.

### ***Revisions to the Medicare Initial Preventive Physical Examination***

§101(b) of the MIPPA amended the requirements for the Initial Preventive Physical Examination (IPPE) also known as the “Welcome to Medicare Physical.” Beginning January 1, 2009, the Medicare deductible no longer applies to the IPPE. Although patients are still responsible for the 20 percent coinsurance amount, it should help alleviate patients’ misconceptions that they were to receive a “free physical.”

MIPPA also expands the eligibility period from the first six (6) months to a full year (first 12 months) after the effective date of the patient’s first Part B enrollment period. Medicare still will only pay for one IPPE per beneficiary lifetime and those Medicare patients who are no longer in the first 12 months of their first Part B enrollment period are not entitled to payment for a screening physical exam.

There are three significant changes in IPPE required services. Effective January 1, 2009, physicians must include the measurement of an individual’s body mass index as part of the IPPE. Physicians must also include end-of-life planning during the encounter.

MIPPA removes the electrocardiogram (ECG) from the list of mandated services that must be included in the IPPE benefit and makes the ECG an educational, counseling, and referral service to be discussed with the patient and, if necessary, ordered by the physician. This change alleviates physician frustration of having to perform a screening ECG when the patient just had a diagnostic ECG. Medicare will cover the screening ECG when the physician deems the screening is appropriate for the individual patient.

To meet these changes CMS, **effective January 1, 2009**, the following codes have been **deleted**:

- ~~G0344~~ Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment
- ~~G0366~~ Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report
- ~~G0367~~ Tracing only, without interpretation and report, performed as a component of the initial preventive examination
- ~~G0368~~ Interpretation and report only, performed as a component of the initial preventive examination

**Effective with IPPE services rendered on or after January 1, 2009**, physicians will use the following codes to report the service(s).

- G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
- G0403 Electrocardiogram, routine ECG with at least 12 leads; performed as a screening test for the initial preventive examination with interpretation and report
- G0404 Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive examination
- G0405 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only, performed as a screening for the initial preventive examination

### ***Smoking and Tobacco-Use Cessation Counseling Services***

Medicare has been covering counseling services for smoking and tobacco-use cessation since March 22, 2005.

Smoking and tobacco use cessation counseling is considered reasonable and necessary for a patient with a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use, or who is taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on FDA-approved information.

CMS specifically states that patients must be competent and alert at the time that services are provided. Minimal counseling, of three (3) minutes or less is included in the payment for the evaluation and management (E/M) visit and is not separately reported.

Although most family physicians provide smoking and tobacco use cessation counseling that lasts more than three (3) minutes in duration, this service is frequently not reported. Medicare covers two (2) cessation attempts per year. Each attempt may include a maximum of four (4) intermediate or intensive sessions, with the total annual benefit covering up to eight (8) sessions in a 12-month period. Physicians and patients have flexibility to choose between intermediate or intensive cessation strategies for each attempt.

Further, intermediate and intensive smoking cessation counseling services are also covered for outpatient and hospitalized patients who are smokers and who qualify as above, as long as those services are furnished by qualified physicians and other Medicare recognized practitioners (e.g., nurse practitioner, physician assistant, etc).

The following *CPT* codes should be reported when billing for smoking and tobacco use cessation counseling services:

- 99406 Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- 99407 Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes

Physicians should also remember that Medicare allows payment for a medically necessary E/M service on the same day as the smoking and tobacco-use cessation counseling service when it is clinically appropriate. Physicians and qualified non-physician practitioners should report the appropriate *CPT* code, e.g., 99201– 99215, for the visit and must append the -25 modifier to the E/M code to indicate that the visit is a separately identifiable service from 99406 or 99407.

Claims for smoking and tobacco use cessation counseling services should be submitted with an appropriate diagnosis code. Due to coverage requirements, diagnosis codes should reflect the condition the patient has that is adversely affected by tobacco use, e.g., diabetes mellitus, chronic obstructive pulmonary disease, etc, or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

CMS has an excellent brochure explaining coverage and coding for Smoking and Tobacco-Use Cessation Counseling Services. This brochure ICN 006767 dated August 2007 is available on the CMS website at <http://www.cms.hhs.gov/MLNproducts/downloads/smoking.pdf>. The brochure includes the following information.

**Cessation Counseling Attempt** A cessation counseling attempt occurs when a qualified physician or other Medicare-recognized practitioner determines that a beneficiary meets the eligibility requirements and initiates treatment with a cessation counseling attempt. A cessation counseling attempt includes the following:

- Up to four cessation counseling sessions (one attempt = up to four sessions)
- Two cessation counseling attempts (or up to eight cessation counseling sessions) are allowed every 12 months.

**Cessation Counseling Session** A cessation counseling session refers to face-to-face patient contact at one of two levels:

- intermediate (greater than 3 minutes up to 10 minutes); or
- intensive (greater than 10 minutes).

**Documentation** Keep patient record information on file for each Medicare patient for whom a smoking and tobacco-use cessation counseling claim is made. Medical record documentation must include standard information along with sufficient patient history to adequately demonstrate that Medicare coverage conditions were met. Diagnosis codes should reflect the following:

- the condition the patient has that is adversely affected by tobacco use; or
- the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

The CMS brochure also clarifies that cessation counseling sessions may be performed “incident to” the services of a qualified practitioner. This means the initial session must be performed by a physician/nonphysician provider. At the physician/nonphysician practitioners’ discretion, follow-up sessions may be performed and documented by ancillary personnel. In this scenario, the billing physician/practitioner must be physically present in the office suite when the counseling services are performed by ancillary personnel.

Physicians have access to Smoking and Tobacco-Use Cessation Counseling Services Eligibility Data to determine the patient’s remaining smoking and tobacco-use cessation counseling sessions and, when appropriate, the next eligible date when the patient has reached their maximum eight (8) sessions, through the 270/271 eligibility inquiry and response transaction. Typically this information is also available through the Medicare Contractor’s Interactive Voice Response (IVR) system.