Billing Alert

Be Prepared for the CPT Code and Billing Changes in 2011

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

1) Communication and Education

> Everyone in your practice should be informed regarding the 2011 CPT code and Medicare changes. CPT code changes for 2011 encompass approximately 416 changes (208 new codes, 110 code revisions and 98 code deletions). Unless otherwise specified, new codes and Medicare changes are effective for services performed on or after January 1, 2011.

Listed below are some key CPT changes that may affect your practice. Be sure to review *CPT® 2011* for other applicable changes. Additionally, watch for updated information on your Medicare contractor's website and other published bulletins.

Evaluation and Management (E/M) Services

• Significant revisions to the CPT Guidelines have been made to the Hospital Observation Services section, including the addition of three new re-sequenced codes in the Subsequent Hospital Observation subsection. Additional revisions have also been made in the Hospital Inpatient Services, Pediatric Critical Care Patient Transport, and Inpatient Neonatal and Pediatric Critical Care subsections.

Anesthesia

• There are no CPT changes to the Anesthesia section of *CPT® 2011*.

Surgery Services

• The Integumentary System subsection has been expanded to include new guidelines to define wound debridement and surface area related to debridement of the subcutaneous tissue, biofilm, epidermis, dermis, muscle, and/or fascia. The subheading *Excision-Debridement* is replaced by only the term *Debridement*. CPT guideline revisions have been made in the Skin Replacement Surgery and Skin Substitutes, the Surgical and Application of Skin Replacements, and the Skin Substitute subsections.
• Musculoskeletal System – In support of the new Category III code 0232T for reporting injections of platelet rich plasma, a cross-reference has been added in the Category I section following 20550, 20551, instructing users to use 0232T for injections of platelet rich plasma.
• Spine (Vertebral Column) – Two new codes (22551 and +22552) were created to report anterior interbody arthodesis procedures and are intended to include discectomies provided at the same level as the arthodesis.
• Endoscopy/Arthroscopy – Three new codes (29914, 29915, and 29916) have been added to the hip arthroscopy family of codes for reporting arthroscopic hip reconstructive procedures. These new codes are noted to be out of sequence with the number (#) symbol.
• Respiratory System – Three new codes (31295, 31296 and 31297) have been established to report endoscopic dilation of the sinus ostia.
• Trachea and Bronchi – A new code (31634) has been created to report bronchoscopy with balloon occlusion, with assessment of air leak, with the administration of occlusive substance, if performed.
• Cardiovascular – Three new codes (33620, 33621 and 33622) are available to report cardiac hybrid procedures. The procedures are distinguished between Stage I and Stage 2.
• Arteries and Veins – Codes 35454, 35456, 35459, 35470, 35473 and 35474 have been deleted to accommodate the addition of new lower extremity endovascular revascularization procedures (37220-37235). Codes 35480-35485, 35490-35495 have also been deleted to accommodate the addition of new lower revascularization procedures (37220-37235) and the atherectomy procedures 0234T–0238T.
• Two new subsections have been added to reflect the comprehensive changes made to the (1) Surgery/Cardiovascular System/Thromboendarterectomy, Transluminal Angioplasy, Intra-Arterial-Intra-Aortic, Transcatheter Procedures sections; (2) Radiology/Vascular Procedures Aorta and Arteries, Transcatheter Procedures, Transluminal Atherectomy sections; and (3) the Category III section.
• Digestive System – Revisions, deletions and additions have been made to multiple codes in the Esophagus section that deal with esophageal and diaphragmatic procedures.

• Urinary System – Category III code 0193T, which described transurethral radiofrequency microremodeling for stress urinary incontinence, has been deleted and converted to Category I status, CPT code 53860.
• Eye and Ocular Adnexa – Two new codes (65778 and 65779) were added to report placement of preserved amniotic membrane over damaged ocular surface tissue either with or without sutures to facilitate ocular surface wound repair and healing.

Radiology

• Three new codes (74176, 74177 and 74178) have been created for reporting combination computed tomography (CT) of the abdomen and pelvis in the Radiology section.
• Revisions have been made to the guidelines of the Diagnostic Radiology (Diagnostic Imaging) Vascular Procedures Aorta and Arteries subsection.
• Five major code revisions have been made to the Vascular Procedures, Transcatheter Procedures subsection.
• Transluminal atherectomy subsection has been deleted to accommodate the addition of the lower endovascular revascularization procedures (37220-37235) and the atherectomy procedures (0234T-0238T).
• Two new codes (76881 and 76882) were added to differentiate a complete extremity ultrasound exam from a focused anatomic-specific ultrasound exam.

Pathology and Laboratory

• 2011 CPT code changes in this section include deletions within the Other Procedures subsection of Pathology and Laboratory with 16 new codes, 7 code revisions and some re-sequenced codes.

Medicine

• The Vaccines, Toxoids subsection has several new code additions. The immunization administration (IA) codes 90465, 90466 90467 and 90468 have been replaced with CPT codes 90460 and +90461 that encompass the delivery of either a multiple-component vaccine product (combination vaccine), which provides protection for multiple diseases or a one-component vaccine product, which provides for a single disease. Differentiation among routes of administration no longer need to be identified to determine code selection; instead, all routes of administration are reflected in codes 90460 and 90461.
• The guidelines in the Medicine Psychiatry section referring to follow-up visits have been revised to make them consistent with other guidelines associated with consultations.
• Category III code 0187T has been converted to a Category I code 92132 due to growth in the national usage of scanning computerized ophthalmic diagnostic imaging. CPT code 92135 has been deleted and split into two new codes 92133 and 92134.
• The Cardiography, Cardiovascular Monitoring Services and Cardiac Catheterization subsection guidelines and codes also have significant revisions. The Cardiac Catheterization section has been restructured to include imaging supervision, interpretation and report. Codes 93501 and 93508-93529 have been deleted. Codes 93452-93461 include contrast injection(s), imaging supervision, interpretation, and report for imaging typically performed. The guidelines have been revised and expanded to provide for appropriate reporting of the new coding structure.
• Sleep study codes 95800 and 95801 have been established for reporting unattended sleep study testing services. These codes appear with a number (#) symbol to indicate that they are out of numerical sequence.

Category II Codes (Tracking Codes for Performance Measurement)

• Category II codes have continued to expand in the CPT code book. A total of 31 new codes for quality measurement have been added. Four new clinical conditions and six revised clinical conditions have been made to this section.

2) Review of Medicare's 2011 Regulatory Changes

• Physician fee schedule update
  - 2009 physician fee schedule rates continued through May, 2010.
  - June 2010 through November 2010 rates increased by 2.2 percent.
  - Without Congressional action, rates to be reduced 23.0 percent on January 1, 2011. Cumulative reduction between November and January = 24.9 percent.
• Therapy Services
  - CMS will apply the therapy Multiple Procedure Payment Reduction (MPPR) when multiple therapy services are billed on the same date of service for the same patient by the same practitioners or facility under the same NPI,

regardless of whether those therapy services are furnished in separate sessions. CMS will apply a 25 percent MPPR in place of the 50 percent reduction proposed.
  - This policy applies to office-based therapy services paid under the Physician Fee Schedule (PFS) as well as to institutional therapy services paid under Part B at the PFS rates.

• Canalith Repositioning
  - CPT code 95992 was bundled in 2009, since it was believed this service would be paid through the accompanying E/M service. CMS has reconsidered this service and changed the code assignment to an active status and will allow as a standalone procedure.

• Section 3108 of Affordable Care Act (ACA): Permitting Physician Assistants (PAs) to Order Post-Hospital Extended Care Services
  - The ACA included a self-implementing provision relating to Skilled Nursing Facilities (SNFs). It adds PAs to the list of practitioners that can perform the required initial certification and periodic recertification with response to the SNF level of care.

• Section 3114 of ACA: Improved Access for Certified Midwife Services (CNM)
  - Effective January 1, 2011 Medicare payment for CNM services will be 100 percent of the PFS amount for the same service furnished by a physician (or 80 percent of the actual charge if that is less).

• Annual Wellness Visit
  - Section 4103 of ACA allows coverage and reimbursement for an annual wellness visit after January 1, 2011 for an individual who is more than 12 months out from the effective date of his/her 1st Medicare Part B coverage period, and has not receive either an Initial Preventive Physical Examination (IPPE) or an annual wellness visit within the past 12 months. Certain criteria for the annual wellness visit must be performed and documented. New G codes (G0438 and G0439) are established for reporting these services.

3) Update Your Fee Schedule

Review the new codes to determine which code changes will impact your practice. Fee schedules should routinely be reviewed and updated annually. We recommend an RVU approach to fee setting with individual code comparison to fee schedules of multiple payers.

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.

The information contained in this advisory is for general educational purposes only. It is presented with the understanding that neither the author nor Anesthesia Resources, LLC is offering any legal or other professional services. This article provides a guide to the most important aspects of the new regulations. When modifying your current policy and practices, please refer to the full text of the regulations.

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