The new year brings refinements to CPT and Medicare codes

New codes, deleted codes, and clarification of just who is a qualified health-care provider are some of the changes that occurred on January 1, 2013

Melanie Witt, RN, CPC, COBGC, MA

Among changes to Current Procedural Terminology (CPT) that took effect on January 1 are several of interest to our specialty:

- the addition of "typical" times to the evaluation and management (E/M) codes for same-day admission and discharge
- a new code for bladder injection
- bundling of imaging guidance associated with percutaneous implantation of a neurostimulator electrode array, if performed, using code **64561**, *Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)*.

In addition, CPT made it clear that all E/M codes can be reported by qualified nonphysician health-care providers, as well as physicians. As for Medicare, coding for administration of depot medroxyprogesterone acetate (Depo-Provera) has been modified, as has the billing process for interpretation of ultrasonography performed outside of the office.

Because of requirements in the Health Insurance Portability and Accountability Act (HIPAA), insurers were required to accept the new codes and revisions on January 1.

Melanie Witt, RN, CPC, COBGC, MA ›› Ms. Witt is an independent coding and documentation consultant and former program manager, department of coding and nomenclature, American Congress of Obstetricians and Gynecologists.

Ms. Witt reports no financial relationships relevant to this article.

Providers can now characterize their level of service by how long it took to provide

As I mentioned, typical times have been added to the set of observation and inpatient care codes that involve admission and discharge on the same date of service. Until now, these codes did not have a pre-assigned typical time, and the provider had to select the level of service based solely on three key components: history, examination, and medical decision-making. The addition of times allows the provider to select the level of service based on counseling or coordination of care, if that activity dominated the visit.

The typical times are:

- **99234**, 40 minutes
- **99235**, 50 minutes
- **99236**, 55 minutes.

Chemodenervation of the bladder gets its own code

A new code, **52287,** *cystourethroscopy, with injection(s) for chemodenervation of the bladder,* has been added to CPT. This procedure is performed to treat idiopathic overactive bladder that can't be managed any other way. It typically involves the injection of botulinum. Before January 1, this procedure was reported using codes **52000** and **64614**, but this approach represented an inexact match.

Payers will be looking closely at diagnostic coding for this procedure. The most

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frequently accepted diagnostic codes are:

- **596.51**, *hypertonicity of bladder*
- **596.54**, *neurogenic bladder NOS*
- **596.55**, *detrusor sphincter dyssynergia*
- **596.59**, *other functional disorder of bladder*
- **788.41**, *urinary frequency.*

Because costs will vary, depending on the chemotoxin used, the agent may be reported separately using the descriptive "J" code or another Medicare-designated alphanumeric code, such as **J0585**, *injection of botulinum toxin type A, 1 unit.*

Qualified providers now include nonphysicians as well as physicians

CPT has clarified that all E/M codes can be reported not only by physicians but by qualified nonphysicians as well.

CPT also changed wording in each of the codes so that the use of counseling time applies to all providers when counseling dominates the visit. In other words, if a payer allows someone other than a physician to provide and bill for a service, the CPT E/M codes can be used by all providers who qualify and have documented the service. These changes have no effect on the codes themselves.

Please note, however, that registered nurses and licensed practical nurses are not normally recognized as billing providers and will still be restricted to code **99211**, *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician.* Usually, with this code, presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services. This code is often referred to as the "nurse-only" code.

As a result of this clarification, references to physicians have been removed from CPT code **59300**, *Episiotomy or vaginal repair, by other than attending.* This change signifies that this code may be reported by any qualified provider who did not perform the delivery or was not covering for a physician group who billed for the delivery.

Three new codes for the flu vaccine

Two of the new codes are CPT codes, and the other is for Medicare:

- **90653**, *Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use*
- **90672**, *Influenza virus vaccine, live, for intranasal use*
- **Q2034**, *Agriflu.*

Keep in mind that the administration of the flu vaccine is reported differently for Medicare, compared with private payers. Administration code **G0008** and diagnosis code **V04.81** would be reported in conjunction with the appropriate vaccine code for Medicare. CPT requires that code **90471** be reported for administration.

CPT also revised all flu vaccine codes (**90655–90660**) to include the term "trivalent" to signify that all flu vaccines are made up of three strains of the virus.

Medicare refines billing for MPA administration

When billing for MPA or MPA in combination with estradiol, be aware that Medicare has eliminated the J codes for these drugs, replacing them with a single new code.

The deleted codes are:

- **J1051**, *medroxyprogesterone acetate, 50 mg*
- **J1055**, *medroxyprogesterone acetate, 150 mg, for contraceptive use*
- **J1056**, *medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg.*

The new code is **J1050**, *medroxyprogesterone acetate, 1 mg.* To use it, you must indicate the dosage as a quantity. For example, if you injected 150 mg, you would use code **J1050 x 150** on the claim. The diagnosis code will indicate the reason for the injection—that is, medical treatment or contraception. In the event that the combination drug is being administered, separate billing of **J1000**, *Injection, depo-estradiol cypionate, up to 5 mg,* would need to be reported in addition to **J1050**.

Medicare has also issued a national policy on Place of Service (POS) billing because the office of the inspector general

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Medicare has eliminated the J codes for MPA with or without estradiol, replacing them with a single new code

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has found that physicians and other suppliers frequently report an incorrect POS, and Medicare pays more for some sites. Medicare rules for the billing of POS for the professional component of an imaging service are changing, effective April 1, 2013. This rule was postponed from its original date of October 1, 2012. Under this rule, when the professional and technical components of a service are performed in different locations, the appropriate POS to report for the interpretive aspect is the location where the technical component was performed. This change would apply to an ObGyn practice that contracts out for the technical component of an ultrasound but performs the interpretation in the office. In that case, the POS should not be listed as "office" or **POS 11**, but should match the POS of the imaging contractor.

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