Internal Medicine Coding Alert

CPT 2002 Codes for Internal Medicine To Face Scrutiny From Medicare

New codes for trigger point injections, administration of intranasal vaccines, and monitoring of physiologic data are among the changes to CPT 2002 of interest to internal medicine practices. Unfortunately, while useful to internists, many of these codes will probably not be reimbursed by Medicare or many private payers.

"All Methods" Removed From Destruction Codes

A change that internists will see is the removal of the phrase "all methods" from procedure descriptions and a list of specific methods inserted in its place. This change is apparent in the codes for the destruction of skin lesions, which have been revised in the following manner: (Changes are in bold.)

1. 17000 destruction (**e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement**), all benign or premalignant lesions (e.g., actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion.

2. 17004 (**e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement**) 15 or more lesions.

3. 17110 destruction (**e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement**), of flat warts, molluscum contagiosum, or milia; up to 14 lesions.

4. 17111 (**e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement**) 15 or more lesions.

5. 17260 destruction, malignant lesion (**e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement**), trunk, arms or legs; lesion diameter 0.5 cm or less.

The changes are primarily stylistic and part of a move toward compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). "HIPAA requires uniformity," according to **Glenn Littenberg, MD, FACP,** a gastroenterologist in Pasadena, Calif., and a member of the CPT Editorial Panel. "CPT is trying to eliminate ambiguities by including a list of examples."

New Codes for Trigger Points, Carpal Tunnel

A major addition to CPT 2002 is the creation of the following separate codes for trigger point injections:

6. 20552 injection; single or multiple trigger point(s), one or two muscle group(s).
7. 20553 three or more muscle groups.

Code 20553 is of special note because it should be used to report multiple trigger point injections, which internists have traditionally had problems billing. "These new codes will help immensely because multiple sites are commonly done and pose the biggest issue when billing for trigger point injections," says **Jim Stephenson,** president of North Central Medical Management, a multispecialty medical billing company in Elyria, Ohio. "The use of modifiers [to signal multiple injections] was pretty complicated because so many carriers had different ways of billing them."

Code 20550 (injection; tendon sheath, ligament, ganglion cyst), which was used previously to report trigger point injections, has now been revised and no longer includes those types of injections.

All injections used to treat carpal tunnel syndrome can now be reported separately with new code 20526 (injection, therapeutic [e.g., local anesthetic; cortico-steroid], carpal tunnel). Medicare and other payers will have to clarify under what circumstances and diagnoses it should be used versus 20550 or 20552. "It's unclear how this code [20526] will pan out, but it is a topic that comes up all the time in internal medicine," Stephenson says. "It looks like, if nothing else, a step in the right direction."

Nasal/Oral Vaccines Get Separate Code

In an attempt to stay ahead of changing medical technology, CPT has created two new codes for the administration of intranasal or oral vaccines. Now, there are no intranasal vaccines on the market, though several are in the process of receiving FDA approval. The new codes are:

8. 90473 immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid).

9. 90474 ... each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure).

Home Health Codes Added

CPT 2002 also includes a new section of codes for home health care services performed by nonphysician providers. While Medicare has not assigned a relative value to any of these codes, individual carriers or private payers may accept these codes. Some that may be of particular interest to internal medicine practices include the following:

10. 99503 home visit for respiratory therapy care (e.g., bronchodilator, oxygen therapy, respiratory assessment, apnea evaluation)

11. 99506 home visit for intramuscular injections

12. 99507 home visit for care and maintenance of catheter(s) (e.g., urinary, drainage, and enteral)

13. 99511 home visit for fecal impaction management and enema administration

14. 99551 home infusion for pain management (intravenous or subcutaneous), per diem

15. 99562 home infusion of total parenteral nutrition, per diem.

These codes are an attempt to standardize the manner in which home-health agencies report their services, Littenberg says. If an internal medicine practice has caregivers other than physicians and PAs or NPs working for them, it may use these codes to report their services. An internist who performs these services, however, should report the appropriate E/M or procedure code."

Note: Physician assistants (PAs) and nurse practitioners (NPs) should check with their payers before billing these home visit codes. Since most PAs and NPs bill the same codes that an internist would, it is likely they would also bill for an E/M service instead of for a home visit, says **Michael Powe,** director of health systems and reimbursement at the American Academy of Physician Assistants in Alexandria, Va.

Nonphysician providers may use new code 95250 (glucose monitoring for up to 72 hours by continuous recording and storage of glucose values from interstitial tissue fluid via a subcutaneous sensor [includes hook-up, calibration, patient initiation and training, recording, disconnection, downloading with printout of data]). This code should be used to report the activities of the internist's staff in the administration of 72-hour glucose monitoring. Those activities could include patient education on how to use the monitor, insertion of the device, initialization of the monitor, and the download of information from the monitor.

"This is a big code for internal medicine practices that deal with a lot of diabetic patients," says **Brett Baker,** third-party-relations specialist at the American Society of Internal Medicine. "While Medicare has assigned a relative value unit of 1.45 to this code, it is unclear at this time whether individual Medicare carriers and other payers will accept it as some concerns have been expressed about the different work inputs involved."

Interpretation of Digital Data

While 95250 is a nonphysician code, another new code, 99091 (collection and interpretation of physiologic data [e.g., ECG, blood pressure, glucose monitoring] digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time), could potentially be used by an internist to report the time he or she spends evaluating the information gathered through the 72-hour glucose monitoring. The code can also be used to report the interpretation of other physiological data, not just glucose monitoring.

While Medicare has not assigned a relative value unit to 99091, Baker sees this code as an important first step in recognizing the value of non-face-to-face communication in patient care. "With increases in technology and increases in the amount of non-face-to-face communication with the patient, this code recognizes the importance of physician review of data and incorporating it into the patient's care plan," he explains. "Right now Medicare says that all communication subsequent to a face-to-face encounter is included in the face-to-face encounter, but technology is making that standard inadequate."

Broader Care Plan Oversight

For the second year in a row, revisions were made to the following care plan oversight codes:

16. 99374 ... physician supervision of a patient under care of home health agency (patient not present) ... **with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s).**

17. 99377 physician supervision of a hospice patient (patient not present) ... **with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s).**

18. 99379 physician supervision of a nursing facility patient (patient not present) ... **with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s).**

By allowing time spent talking with family members to be included, these revisions broaden the definition of what CPT considers to be oversight services, Baker says. "Family members are likely to spend more time with the patient in these circumstances and can provide valuable information that the internist may incorporate into the plan of care," he explains.

Medicare was so dissatisfied with the changes CPT made to these codes last year that it chose to create its own care plan oversight codes (G0181 and G0182) rather than accept the revised CPT codes. Baker thinks it is likely that Medicare will continue to require its own HCPCS codes for care plan oversight this year as well.

CPT 2002 goes into effect on Jan. 1, 2002. However, a three-month grace period allows providers to use either CPT 2001 or 2002 codes until March 31, 2002. Medicare's decision on which codes to accept and what relative value units will be assigned to them was not available when this article went to press, but can be accessed in the Federal Register in early November. RVU changes that affect internists will be discussed in future issues.

Internists should also ask their private insurers which codes they will accept. "Another aspect of the CPT changes is working with private insurers to see who will accept what and how to report it," Baker says. "Medicare's decision to accept a code or not, however, certainly has implications for non-Medicare payers because many private insurers follow Medicare."