Internal Medicine Coding Alert

CPT® 2014 Update: 2014 Changes: Gear Up With New Year CPT® Codes

Good News: You will now have a new code set for inter-professional discussions.

If you are wondering what 2014 has in store for you, you don't have to wait for the new CPT® book to release to find coding changes you need to incorporate into your family practice. While official CPT® changes have not been released, take a look at what you can expect come Jan. 1, 2014.

Reminder: Although the potential revisions below are listed as "accepted" in the CPT®editorial panel meeting summaries, it is not given that all these changes will appear in CPT® 2014. Also, the actual codes, descriptors, and guidelines won't be finalized until closer to the time of CPT® 2014's official publication later this year.

New E/M Codes For Discussions on Patient Condition

Although the proposed changes in 2014 are not much when it comes to evaluation and management (E/M), you are likely to see new codes to report the work of two medical professionals who discuss a patient's condition via phone or internet. So, beginning Jan.1, 2014, you are likely to have four new codes using the code range 9944X to describe this work, depending on the time spent for this consultative service.

"These new codes are intended to be used only by the consultant physician," notes **Kent Moore,** senior manager for physician payment at the American Academy of Family Physicians. "The patient's treating physician, which is typically the attending or primary care physician, who is seeking the consultant's opinion or advice with respect to diagnosis and/or management of the patient will not be able to use these codes for his or her portion of the conversation. That said, if a family physician is consulted by another physician or other qualified health care professional in this way, there is nothing to preclude the family physician from reporting these codes," adds Moore

However, it isn't clear whether Medicare will include payment for these codes, since they are consultations, so keep an eye on future issues of the Family Practice Coding Alert for more on whether these are payable once the final 2014 Medicare Physician Fee Schedule is released.

Observe Changes to Vaccination Codes

As with every year, CPT® 2014 is also likely to see some changes to codes that you use for vaccines. One of these is 90673 (Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutnin (HA) protein only, preservative and antibiotic free, for intramuscular use). "This code, which was FDA approved in January 2013, was released on July 1, 2013, for implementation on January 1, 2014," says Moore.

The other influenza vaccine codes that CPT® announced will make their way into CPT® 2014 may not be in the code book yet, but have already been valid to report since Jan. 1, and include the following:

- 90685 □ Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
- 90686 □ ...when administered to individuals 3 years of age and older, for intramuscular use
- 90687 □ Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use

- 90688 ⚡ ...when administered to individuals 3 years of age and older, for intramuscular use

Note: The codes 90687 and 90688 carry a lightning bolt sign which means that these codes are still awaiting FDA approval. These two codes carried the symbol in CPT® 2013 and are still carrying the same status in CPT® 2014.

To read about the new vaccine codes, visit www.ama-assn.org/resources/doc/cpt/vaccine-codes.pdf.

Understand Descriptor Changoes to Cerumen Removal

Until now, whenever your physician performed cerumen removal, you would report it with 69210. If you look at the current descriptor of 69210 (Removal impacted cerumen [separate procedure], 1 or both ears), you'll observe that you will only report the code once, even if your physician performed the cerumen removal in both the ears. However, in 2014, this will probably change, if the recommended descriptor change comes into force.

As per the new descriptor proposed, there is a change to remove the "one or both ears" portion of the code descriptor and replace it with the word "unilateral." If this change is implemented, you'll have to report cerumen removal for each of the ears separately. So, when your clinician performs cerumen removal in both the ears, you'll have to append the bilateral modifier 50 (Bilateral procedure) to 69210. In such a case, you'll report 69210-50 to indicate that the procedure was done in both the ears.

"From a CPT® perspective, you append modifier 50 to the appropriate unilateral code as a oneline entry on the claim form to indicate that the procedure was performed bilaterally," observes Moore. "Accordingly, when you report 69210 with modifier 50 appended to it, the units box on the claim form should indicate that you provided'1' unit of service, because your physician did 69210 bilaterally. Although this approach reflects the intent of CPT®, some payers may require that the code be listed twice, with modifier 50 appended to the second line entry, so contact the payers with whom you deal most often regarding their respective reporting guidelines," adds Moore.

In addition, although Medicare payers specifically indicated that practitioners had to use instrumentation when removing impacted cerumen to qualify for 69210, CPT® now follows that lead and puts it right in the code description, with the full descriptor now stating, "Removal impacted cerumen requiring instrumentation, unilateral." Therefore, using ear lavage, water pik, or ear washings will not qualify for 69210, because they don't qualify as instrumentation. Instead, items like forceps or wax curettes are considered instrumentation.

New Code for Ultrasound Wound Care Therapy

If your clinician is performing the application of a low frequency ultrasound device for wound care, you had to use the Category III code 0183T (Low frequency, non-contact, non-thermal ultrasound, including topical application[s], when performed, wound assessment, and instruction[s] for ongoing care, per day) to report the procedure in 2013. In CPT® 2014, you will have a new option as the old Category III code 0183T will be deleted, and in its stead, you will have a new Category I CPT® code to report the procedure.

Caveat: Many payers do not provide coverage for Category III codes. Some payers, even if they are providing coverage for these codes, might require pre-authorization or else your claims might get denied. As ultrasound wound care therapy is all set to get a Category I code, the chances of denial will likely get reduced, and you might soon not need pre-authorization to get coverage for the procedure if your clinician performs it.