Internal Medicine Coding Alert

CPT® 2015 Update: Preview Your 2015 Vaccine Codes With New, Revised CPT® Updates

Check out new additions to arthrocentesis procedures that involve guidance.

If you have been wondering at what new changes you will be facing with CPT® 2015, here is a first look at what you can expect. You will be seeing some new codes for vaccinations, arthrocentesis, and chronic care management while having to take into account some descriptor changes to old codes.

Observe Changes to Vaccination Codes

As with every year, you will be seeing some changes to vaccination codes in CPT® 2015. You will have to add two new vaccine codes to your cache while making note of many changes to the descriptors of old codes.

The two new codes that you will be seeing in 2015 include:

- 90630 (Influenza virus vaccine, quadrivalent [IIV4], split virus, preservative free, for intradermal use)
- 90651 (Human Papilloma virus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent [HPV], 3 dose schedule, for intramuscular use)

In addition, you will be seeing the following descriptor changes in CPT® 2015:

- 90654 (Influenza virus vaccine, trivalent [IIV3], split virus, preservative-free, for intradermal use)
- 90721 (Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib)[DTaP/Hib], for intramuscular use)
- 90723 (Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitishepatitis B, and inactivated poliovirus vaccine, inactivated (DtaP-HepB-IPV) [DTaP-HepB-IPV], for intramuscular use)
- 90734 (Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), quadrivalent, for intramuscular use)

Note: The new codes, 90630 and 90651, carry the lightning bolt (~) sign that indicates that these codes are still awaiting FDA approval.

The revisions to the existing codes are primarily editorial or otherwise made to distinguish the existing codes from new codes that will appear in 2015. For instance, the addition of the word 'trivalent' to 90654 is primarily for the purposes of distinguishing it from new code 90630, which is a quadrivalent vaccine.

Watch Out For Changes to Arthrocentesis Codes

According to the proposed changes to CPT® codes in 2015, you will be seeing some changes to the descriptors of codes that you would use to report arthrocentesis. You will also have to take into account some new codes being introduced for these procedures when they involve ultrasound guidance.

The descriptor changes and the new codes that you will see for arthrocentesis include:

- 20600 (Arthrocentesis, aspiration and/or injection, small joint or bursa [e.g., fingers, toes]; small joint or bursa (eg, fingers, toes)without ultrasound guidance)
- 20604 (...with ultrasound guidance, with permanent recording and reporting)
- 20605 (Arthrocentesis, aspiration and/or injection, intermediate joint or bursa [e.g., temporomandibular,

acromioclavicular, wrist, elbow or ankle, olecranon bursa]; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)without ultrasound guidance)
- 20606 (...with ultrasound guidance, with permanent recording
- and reporting)
- 20610 (Arthrocentesis, aspiration and/or injection, major joint or bursa [e.g., shoulder, hip, knee, subacromial bursa]; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)without ultrasound guidance)
- 20611 (...with ultrasound guidance, with permanent recording and reporting)

Coding tip: You will have two different codes for any arthrocentesis procedure depending on whether or not your clinician used ultrasound guidance for placement of the needles in the joint. So, you will have to look at documentation to ascertain the use of ultrasound guidance to arrive at the right CPT® code for the procedure performed.

"Note that the new arthrocentesis codes with imaging guidance only refer to ultrasound guidance," an expert pointed out. "If your physician uses some other sort of imaging guidance, that remains separately reportable, as it is now."

Embrace the Chronic Care Management Improvements

Changes to five CCM codes may make your chronic care management services coding less of a chore.

You'll find that CPT® 2015 revises the descriptor for 99487 with bulleted detail as follows: (Complex chronic care coordination management services, with the following required elements:

- multiple [two or more] chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- establishment or substantial revision of a comprehensive care plan;
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

"Adding the elements is definitely a positive; it gives the provider community a set of guidelines to follow to meet the documentation requirements of the codes," says **Suzan Berman (Hauptman), MPM, CPC, CEMC, CEDC**, director of coding operations-HIM at Allegheny Health Network in Pittsburgh, Pa. "Often we find that the providers are performing the services, but aren't necessarily illustrating them as the payer would like to see in the documentation."

In addition, you'll see that CPT® 2015 deletes 99488 (Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month).

Don't miss: For each additional 30 minutes of chronic care management your physician provides, you will still be able to report revised add-on code +99489 (Complex chronic care coordination management services. . .; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month [List separately in addition to code for primary procedure]).

Bonus: You will also have two new CCM codes to choose from:

1. 99490 □ Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,

chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,

comprehensive care plan established, implemented, revised, or monitored

2. +99498 □ ... each additional 30 minutes ....

These changes appear to be primarily in response to the Centers for Medicare & Medicaid Services' (CMS) proposal to establish its own "G" code for chronic care management along the lines described in code 99490.