Internal Medicine Coding Alert

CPT® 2016 Update: Get Prepared For Internal Medicine Code Changes in CPT® 2016

Stay tuned for reimbursement answers.

September is here, and with it comes the annual unveiling of new, revised, and deleted CPT® codes for the following year. Initial sneak peeks don't show many updates for internal medicine codes, but you'll still want to be aware of how your reporting might change in 2016.

New Option for Cerumen Removal

CPT® 2016 introduces only a few new codes related to internal medicine, but they could be important additions to your coding mix especially one that changes how you report cerumen removal.

The procedure has been a point of interest for internal medicine coders in recent years, especially with the battle over whether you can report 69210 (Removal impacted cerumen requiring instrumentation, unilateral) as bilateral with modifier 50 (Bilateral procedure).

Coding guidelines have always stated that you must have documentation of the cerumen being impacted before you can submit 69210. If the cerumen wasn't impacted or if the physician didn't use any type of instrumentation during the removal, the service was included in a typical evaluation and management (E/M) code such as 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components ...).

CPT® 2016 will change that with new code 69209 (Removal impacted cerumen using irrigation/lavage, unilateral).

"This is basically what primary care doctors do to remove cerumen," explains **Barbara J. Cobuzzi, MBA, CPC, COC, CPC-P, CENTC, CPCO,** vice president of the coding and consulting division of J. & S. Stark Billing & Consulting, Inc., in Shrewsbury, N.J.

Important: Physicians will have to demonstrate that their E/M is a significant and separately identifiable service (represented by modifier 25) in order to bill an E/M and the new code 69209 if it is not status B (bundled) in the payer's fee schedule. "Once the insurers release their fee schedules, it will be important to determine whether 69209 has a status of "B," meaning that it's bundled with the E/M and therefore cannot be reported separately," says Cobuzzi. "Primary care doctors will have to demonstrate that their E/M is significant and separately identifiable (25 modified) in order to bill an E/M and the new code 69209 if it is not status B," she advises. Check the Medicare Physician Fee Schedule for the latest on reimbursement and status of any procedure.

Changes to Vaccine Codes

As with every year, you will see some changes to vaccine codes in CPT® 2016. You will have to add four new vaccine codes to your kitty while making note of many changes to the descriptors of old codes.

The four new codes that you will see in 2016 include:

- 90620 (Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B [MenB], 2 dose schedule, for intramuscular use)
- 90621 (Meningococcal recombinant lipoprotein vaccine, serogroup B [MenB], 3 dose schedule, for intramuscular use)
- 90625 (Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use)
- 90697 (Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine [DTaP-IPV-Hib¬-HepB], for intramuscular use)

In addition, you will see descriptor changes to many of the vaccine codes that you may use in your practice. Also, you will see some of the old codes disappearing when CPT® 2106 comes into effect.

Check on Descriptor Changes to Prolonged Care and CCM Codes

When CPT® 2016 goes into effect, you will not only have to be aware of some of the new codes that have been added and the deletion of old codes; you will also need to be aware of descriptor changes to some of the codes. One such set of codes that you will need to pay attention to are the prolonged care codes.

You will see the following descriptor changes to these codes in CPT® 2016:

- 99354 (Prolonged serviceevaluation and management or psychotherapy service[s] [beyond the typical service time of the primary procedure] in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour [List separately in addition to code for office or other outpatient Evaluation and Managementor psychotherapy service])
- 99355 (Prolonged serviceevaluation and management or psychotherapy service[s] [beyond the typical service time of the primary procedure] in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes [List separately in addition to code for prolonged service])

"Parentheticals in CPT® following the prolonged services codes and code 90837 (Psychotherapy, 60 minutes with patient and/or family member) already specify that prolonged service codes can be used in addition to 90837 for psychotherapy services not performed with an E/M service of 90 minutes or longer face-to-face with the patient," says a coding expert. As prolonged care codes are used with E/M and also with psychotherapy services when the service extends beyond typical time, the new descriptors have added language consistent with these parenthetical instructions.

Get to Know 99415 and 99416

CPT® 2016 will include two new add-on E/M codes to help you capture work your clinical staff performs after your internal medicine specialist sees the patient for an E/M service. You will be able to report 99415 (Prolonged clinical staff service [the service beyond the typical service time] during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour [List separately in addition to code for outpatient Evaluation and Management service]) and 99416 (...each additional 30 minutes [List separately in addition to code for prolonged services]) to seek additional, deserved reimbursement.

"Now, here is a set of codes to really sink your teeth into; we hope!" says **Suzan (Berman) Hauptman, MPM, CPC, CEMC, CEDC,** director of PB Central Coding at Allegheny Health Network in Pittsburgh, Pa. "Often times, a physician's time with the patient only paints a partial picture of what occurred during the visit. It could have been that the staff was asked to give an injection, but the patient was uncooperative. It might include education for a new medication, therapy, or options for care that go far beyond the time illustrated in the E/M code, but that education doesn't have to be that of the physician. The staff members in a physician's office are important to the care of the patient and also are an expense to the physician. These codes make good sense all around to be included in the new code sets. This may also come into play with the trend of coverage for more preventive services. I am anxious to see how these codes play out in policy and, if reimbursable, what might that reimbursement look like."