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Internal Medicine Coding Alert

Take Advantage of Reporting More AT-Home Care With New CPO Codes

CPT 2006 expands 993xx series, adds modifier 25 documentation language

Entry-level services to homebound patients who are not under the care of a home health agency, hospice or nursing home will no longer fall through the cracks thanks to CPT 2006's introduction of new care plan oversight codes.

The AMA has released the tentative agenda for its CPT 2006 Coding Symposium, to be held Nov. 17 and 18 in Chicago. The agenda gives the first official clues as to which areas next year's coding changes will address.

When the 2006 CPT updates take effect Jan. 1, 2006, internists will face three major E/M changes:

• two new care plan oversight (CPO) codes that do not stipulate the patient must be under the care of a home health agency, hospice or nursing home

• clarified modifier 25 explanatory text that specifies documentation must support the significant and separate E/M claim

• deletion of the follow-up inpatient consultation codes (99261-99263, Follow-up inpatient consultation for an established patient ...) and confirmatory consultation codes (99271-99275, Confirmatory consultation for a new or established patient ...). For more information on consultation code changes, see "Introducing CPT's 'Win-Win' Routine Hospital Care Coding" and "Expect Confirmatory Consult Cut to Cost You More Than $35" later in this issue.

Don't Use 99374-99380 for Basic Performed Services

CPT 2006 will expand CPO services to include two new codes to describe CPO services without the caveat that a home health agency, hospice or nursing facility has to supervise the patient's care.

Current method: You may now only report CPO services when the patient is:

• under the care of a home health agency--99374 or 99375 (G0181 for Medicare).

• on hospice--99377 or 99378 (G0182 for Medicare)

• a nursing facility patient--99379 or 99380.

The supervision restriction closes the door on reporting CPO services for homebound patients who require only entry-level services. "Because these patients do not need full-time care, supervision by a home health agency, hospice or a nursing home is unnecessary," says **Patricia Bukauskas-Vollmer, CMM, CPC, CMSCS,** president and CEO of TB Consulting in Myrtle Beach, S.C. Therefore, the service does not meet 99374-99380 or G0181-G0182's criteria.

Result: "The internist overseeing the patient's care could not code for the home healthcare worker's services incident-to the physician," Bukauskas says. In 2006, however, you will have new codes that account for this work.

Capture More Work With New CPO Codes

The two new codes will make additional services eligible for CPO reporting. "When a non-home healthcare worker provides an entry-level service, the new codes will make the service billable," Bukauskas says. Translation: Internists will be able to charge for more work that they already supervise.

Tip: To capture CPO services, include a time and work type worksheet in each patient's chart. The home healthcare worker must document and time each service that she provides to the patient. Paperless offices can put this documentation in electronic form or in a dictation.

Important: The AMA still has to determine the codes' last two digits. The panel now refers to the codes as 993xx.

Include Supporting Notes for 25

You probably already know that you append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) only when the internist's documentation supports a significant and separate service--but CPT 2006 wants to drive home this requirement.

The new explanation will state that a "significant, separately identifiable E/M service" should have documentation that meets the requirements for the E/M service being reported.

Translation: Modifier 25 claims do not have to contain any new documentation criteria, says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME**, president of CRN Healthcare Solutions in Shrewsbury, N.J. "CPT is just clarifying that documentation must show the E/M service is significant and separate from the same-day procedure, preventive medicine or other service."

"Physicians should have been documenting modifier 25 services this way all along," says **Victoria S. Jackson,** owner of OMNI Management Inc. in California. "I always tell physicians that their documentation must support the E/M components of history, examination and medical decision-making as a stand-alone service from the procedure billed."