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CPT 2000 Changes Affect Physical Medicine and Rehab Practices

Coding Insight: CPT 2000 adds, deletes and clarifies codes like 97150 that affect physiatrists coding and reimbursement into the new year.

The new CPT 2000 contains notable changes for physiatrists to the evaluation and management (E/M), surgery, radiology and medicine codes, as well as the addition of a new modifier. Youll find the full listing of additions, deletions and revisions arranged by CPT code number in Appendix B of the new manual, but the following items highlight the changes that most directly affect physical medicine and rehabilitation (PM&R) practices.

1. E/M Services: Time Guidelines Offered. For those offices, rehabilitation centers and hospitals in which doctors are coordinating care with non-family members, **Laura J. Walsh, JD**, policy analyst at the American Academy of Physical Medicine and Rehabilitation, tells us that **CPT Codes** 2000 holds an important change in the Guidelines/Tips section of E/M services. According to the revision, says Walsh, time may be considered the key or controlling factor to qualify for a particular level of E/M services if counseling and/or coordination of care dominates (more than 50 percent) the physician/patient and/or family encounter.

CPT 2000 also explains that this change includes time spent with parties who have assumed responsibility for the care of the patient or decision making, whether or not they are family members.

The change is significant because it applies to both office visits (**CPT 99201** - **99215**) and floor/unit time in hospitals or nursing facilities (99217-99239), which would include rehabilitation centers. For example, the doctor who confers with a quadriplegic patients roommate about moving the patient to a full-time nursing facility can bill for the time spent talking to the roommate if the roommate is the person who has assumed responsibility or decision-making, says Walsh. This would not be the case if there is another family member with this responsibility.

2. Consultations With Treatment. CPT 2000 also clarifies when you can bill a consult if the doctors must begin to administer treatment. The revision states: A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

In the past, says Walsh, our members were not being paid for a consultation when they initiated treatment at the same visit as the consultation. For example, when a patient comes in for a consultation and needs a trigger point injection at the same time. Now if they determine a specific treatment is required, they may initiate it on the same day and still be paid for a consultation as long as all the requirements for a consultation have been met.

For those requirements, CPT 2000 states, The written or verbal request for a consult may be made by a physician or other appropriate source and documented in the patients medical record. The consultants opinion and any services that were ordered or performed must also be documented in the patients medical record and communicated by written report to the requesting physician or other appropriate source.

3. Surgery Guidelines: Starred Procedures. Many PM&R offices rarely deal with surgical codes other than injections. But sometimes their coders bill for orthopedic surgeons or for rehabilitative treatments, making it important to understand the CPT 2000 revision to the surgery section: When a starred procedure occurs at the time of an initial or established patient visit involving significant identifiable services, the appropriate visit is listed with the modifier -25 [significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service] appended in addition to the starred procedure and its follow-up care. This is particularly important for those billers who have been writing off the cost of the E/M service when performing starred procedures, such as injections, on the same day as the consult.

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4. Modifier -91 Added. Modifier -91 (repeat clinical diagnostic laboratory test) should be billed when a laboratory test is performed more than once on the same patient on the same day to obtain subsequent (multiple) test results, the guidelines indicate. The code is not to be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time reportable result is all that is required, according to CPT 2000.

5. Musculoskeletal System: Ultrasound Stimulation. Physiatrists who have been billing ultrasound stimulation for bone healing as code 20999 (unlisted procedure, musculoskeletal system, general) will be relieved to see that a new code has been added to the Unlisted Procedures section. Code 20979 (low intensity ultrasound stimulation to aid bone healing, noninvasive [nonoperative]) now will fill the need for more specificity in offices, hospitals and rehabilitation centers that are using bone stimulators for patients experiencing such problems as delayed healing.

6. Fluoroscopic Guidance During Spine and Spinal Cord Surgery. Under the Injection, Draining or Aspiration heading, injection of contrast during fluoroscopic guidance and localization is inclusive within codes 62270-62273; 62280-62282; and 62310-62319, according to the new CPT 2000. It indicates that fluoroscopic guidance and localization should be coded as 76005, unless a formal contrast study (myelography, epidurography, or arthrography) is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes.

The Injection, Draining or Aspiration heading also includes five new codes significant to physiatrists:

62263percutaneous lysis of epidural adhesions using solution injection (e.g. hypertonic saline, enzyme) or mechanical means (e.g., spring-wound catheter) including radiologic localization (includes contrast when administered).

62310injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic.

62311lumbar, sacral (caudal).

62318injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for
either localization or epidurography) of diagnostic or
therapeutic substance(s) (including anesthetic, antispas-modic, opioid, steroid, other solution), epidural or sub-arachnoid, cervical or thoracic.

62319lumbar, sacral (caudal).

Note: When using 62318 and 62319, CPT 2000 indicates that subsequent daily management of epidural or subarachnoid catheter drug administration should be billed using code 01996 (daily management of epidural or subarachnoid drug administration).

**7. Extracranial Nerves, Peripheral Nerves
and Autonomic Nervous System.** New codes for injections of diagnostic or therapeutic nerve blocks for the somatic nerves include:

64470injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level.

64472cervical or thoracic, each additional level (list separately in addition to code for primary procedure). This code is to be used in conjunction with code 64470.

64475lumbar or sacral, single level.

64476lumbar or sacral, each additional level (List separately in addition to code for primary procedure). This code is to

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be used in conjunction with code 64475.

64479injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level.

64480cervical or thoracic, each additional level. (List separately in addition to code for primary procedure). This code is to be used in conjunction with code 64479.

64483lumbar or sacral, single level.

64484lumbar or sacral, each additional level. (List separately in addition to code for primary procedure). This code is to be used in conjunction with code 64483.

CPT 2000 also adds two new and noteworthy codes for Destruction by Neurolytic Agent (e.g., Chemical, Thermal, Electrical, Radiofrequency. New codes 64622 (destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level), 64626 (cervical or thoracic, single level), and the new add-on code 64627 (cervical or thoracic, each additional level) should help coders who rely heavily on 64640 (other peripheral nerve or branch).

8. Radiology Guidelines. Three new radiology codes have been added in the Other Procedures section that should be of particular assistance to those PM&R offices that bill directly for their radiology services:

spine and pelvis code 72275 (epidurography, radiological supervision and interpretation);

lower extremity code 73542 (radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation); and

76005 (fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint], including neurolytic agent destruction).

Under code 76005 in the Other Procedures section, CPT 2000 includes new information to clarify the correct radiology codes used for the following issues:

Injection of contrast during fluoroscopic guidance and localization (62270-62273, 62280-62282, 62310-62319);

Fluoroscopic guidance for subarachnoid puncture for diagnostic radiographic myelography (72240, 72255, 72265, 72270);

Epidural or subarachnoid needle or catheter placement and injection (62270-62273, 62280-62282, 62310-62319);

Sacroiliac joint arthrography (27096, 73542, 76055);

Paravertebral facet joint injections and transforaminal epidural needle placement and injection (64470-64476, 64479-64484); and

Destruction by neurolytic agent (64600-64680).

9. Injection Guidelines. The former Therapeutic or Diagnostic Injections subsection now includes prophylactic injections. This change affects the following codes:

90782 (therapeutic, prophylactic or diagnostic injection [specify material injected]; subcutaneous or intramuscular) and

90799 (unlisted therapeutic, prophylactic or diagnostic injection).

Although many prophylactic injections were covered in the past (such as tetanus shots), the revision is designed to

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support the legitimacy of billing prophylactic injections, says Louis Arancia, DPM, FAAHP, FACFAS, executive director of the American Association of Hospital Podiatrists.

10. Neurology and neuromuscular procedures. CPT 2000 does not designate any new codes for this section but lists revisions for several existing codes that will affect those practices with neurologic rehabilitation specialties and offices that perform electrodiagnostic tests. The guidelines summarize those revisions as:

95816electroencephalogram (EEG) including recording awake and drowsy (including hyperventilation and/or photic stimulation when appropriate).

95819electroencephalogram (EEG) including recording awake and asleep (including hyperventilation and/or photic stimulation when appropriate).

95831muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk.

95870limited [eletromyography] study of muscles in one extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters.

95900nerve conduction, amplitude and latency/velocity study, each nerve; motor, without
F-wave study.

95904nerve conduction, amplitude and latency/velocity study, each nerve, sensory or mixed.

95961functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of physician attendance.

11. Physical medicine and rehabilitation guidelines. The only change in the PM&R category itself is the clarification of code 97150 (therapeutic procedure[s], group [2 or more individuals]). The code now specifies that billers should report this code for each member of a group. Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist, says CPT 2000. These revisions simply clarify an existing policy and should not make any significant difference in the way billers submit group therapy claims, says Arancia.

Note: Susan Callaway-Stradley, CPC, CCS-P, an independent coding consultant and educator in North Augusta, S.C., also served as a source for this article.

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