An Update on CPT and Regulatory Changes for 2007

The new year brings many revisions to billing procedures that need to be implemented to ensure prompt reimbursements and avoid claims denials.

By Mary H. McDermott

Every January, the *Current Procedural Terminology* manual is updated to reflect changes in the practice of medicine and, hopefully, to clarify and refine the perpetually-confusing process of coding for services. The CPT 2007 contains some important changes that will impact neurology practices. Though the actual changes that affect neurology are few, they are significant.

This year, the CPT editorial panel added new codes for fMRI and genetic counseling. More importantly, significant changes were made to the CPT guidelines, introductory notes, explanatory text, headings and cross-references for 2007. This will impact the proper use of existing codes, so these changes cannot be discounted. Lastly, due to a comprehensive re-organization of the radiology chapter that makes it easier to code for imaging guidance, many of these codes were re-numbered. As a result, most of the radiology cross references throughout the surgical sections were revised. Any neurology practice that performs procedures with radiologic guidance will need to update its billing procedures.

The New Codes

The growing popularity of fMRI and the increased need for genetic counseling are now reflected in additional codes for these two items:

fMRI. A new CPT code, 96020, has been established for the neurologic testing component of fMRI. The code includes neurofunctional testing selection and administration during non-invasive imaging and functional brain mapping. This code is to be used only when the service is entirely performed by an MD or psychologist PhD and includes review of testing results and report generation.

Unlike the existing neuropsychological testing codes (96116-96119), this is not a time-based code and is billed once per day. This code cannot be billed in addition to the psychological codes (96101-96103) and neuropsychological testing codes (96116-96120). In addition, CPT instructions tell you not to bill related evaluation and management codes on the same day as the 96020. This code should not be reported for testing performed by a technician.

The companion radiology codes to the fMRI code are 70554 or 70555. Depending on the site of service, a 26 modifier may be appropriate. If the neurologist is also interpreting the MRI component of fMRI, use code 70555 in addition to the 96020. If a technician is performing the testing, the only code that could be billed is 70554, which bundles the testing component. Code 96020 should never be billed with code 70554.

Beware: if the technician who performs the testing is employed by the neurologist or a hospital and a radiologist is supervising and interpreting the MRI, there is no billable code for the neurologist. The neurologist cannot bill code 96020 if he or she only interprets the results of the testing; rather, the neurologist must actually perform the entire service. The 96020 and 70555 codes were purposely designed with no overlap of physician work effort or practice expense; given that they are new codes, you will need to vigorously appeal any inappropriate denials for bundling.

Genetic Counseling. A new code for genetic counseling services has been established, and it resides under a new sub-section of the CPT's Medicine chapter entitled "Medical Genetics and Genetic Counseling Services." These services are frequently provided to pediatric neurology and adult neuromuscular patients in MDA-supported clinics, or as a part of other neurologic specialty clinics where the disease process has identified genetic components.

Code 96040 was developed to report the time-intensive services of trained

genetics counselors. Prior to the establishment of this code, the only alternative for physician-employed genetics counselors was to report their services "incident to" the physician using CPT code 99211, which significantly under-reported their time and work effort. If the physician had already billed another E/M code that day for that patient, there could be no additional billing. Services included in this code are the obtaining of a structured family genetics history, pedigree construction, analysis for genetic risk assessment, and counseling of patient and/or family.

This is a time-based code and is reported for each 30 minutes of service (*i.e.*, two hours is four units). In keeping with CPT conventions for other time-based codes, a threshold of at least 16 minutes is needed to bill the first occurrence and each additional unit after the first.

CMS has already established that it will not cover code 96040. SSI disability beneficiaries will be adversely impacted by this decision. When providing these services to this population, a properly executed ABN needs to be signed, making the patient liable for the payment. In addition, CMS and most private payers do not recognize genetics counselors as billable providers of service, so in essence this long-overdue code will be a reimbursement challenge for most practices. No physician work RVUs were assigned to this code because it was designed to be reported only when a trained genetics counselor provided services. Counseling services provided by a physician should be reported using the appropriate level of E/M code and are usually best reported based on time.

The Medical Genetics subsection was specifically created because the CPT editorial panel felt that in coming years there will be a significant increase in the number of genetic medicine services that will become available.

Category II Codes. These codes were established to report performance measures and will factor significantly in pay-for-performance reporting. New codes were added for COPD, diabetes, community-acquired pneumonia, mental status assessment, and an additional category was established for preventive care and screening.

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Category III Codes. These codes are used for new and emerging technologies. Of the 30 new codes that were added to this section this year, the two codes that will be of most interest to neurologists and neuropsychologists are the codes for therapeutic repetitive transcranial magnetic stimulation treatment planning (0160T) and therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session (0161T). These codes join the category III codes for QST. Category III codes are the precursor to category I codes. If a category III code exists for a service, it must be used.

Guideline Changes Most Likely to Affect You

By far, the most important changes this year are the clarification of selected evaluation and management guidelines and the publication in CPT 2007 of a decision tree that now assists you in determining whether your patient should be billed as a new patient or an established patient. CPT takes the additional step this year of clarifying the relationships between testing, results and reports. This change appears at the beginning of each of the main sub-sections including the Medicine section, where the great preponderance of neurologic testing codes reside, and in essence, establishes a standard of documentation for interpretative reports.

E/M Services. Consultation guidelines have been clarified to indicate that consultations initiated by the patient or the patient's family should be billed as either new or follow-up E/M services based on the appropriate setting, but should not be billed as consultations. This brings into focus the issue of patients who want to see a specialist and require a referral from their PCP to do so. Just because the patient presents with a referral does not mean the service should be billed as a consultation. The administrative requirement of obtaining a referral is not the driver of the code selection.

CMS has clarified that it expects to see the nature of the request documented in the medical record, and that a report must be sent back to the referring provider. The consult guidelines further enumerate what are considered "appropriate referral sources." PAs, NPs MDs, psychologists, OTs, PTs, chiropractors, SLPs, social workers, lawyers and insurance companies are all considered by CPT to be appropriate referral sources. Note, however, that CMS has clarified

that it does not consider referrals from lawyers or insurance companies medically necessary and as a result these consultations referred from these sources are not payable by Medicare. It is also unclear how lawyers and insurance companies would go about obtaining NPIs or acting upon a plan of care outlined by the consultant for the referred problem so this particular clarification almost seems counterproductive.

It is important to note that consultation services, while not specifically listed on the Office of the Inspector General's 2007 work plan, continue to garner attention by CMS because of the potential for improper billing and the increasing expenditures related to these services. The key to proper billing of consultation services is making sure you document the request for advice, and that you ensure a report of the consultation is sent back to the requesting provider.

Outpatient Consultations. There has been tremendous uncertainty among providers as to when it's appropriate to bill consultation codes 99241-99245 instead of new patient visit codes 99201-99205. This is in part due to the gray areas of transfer of care, and due to the seemingly contradictory instructions in CPT and from CMS in their transmittal 788 dated 12/20/2005.While CPT does not address the issue of transfer of care, it has taken steps to clarify that if the provider assumes management of a patient's condition subsequent to the performance of a consultation, the subsequent visits would be reported using the subsequent care codes for the appropriate site of service. It further explains that additional consultations may be billed on the same patient if an additional request for an opinion or advice regarding the same or a new problem is received from an appropriate source.

While the above clarifications will be helpful to many providers in accurately reporting their services, there will still be uncertainty surrounding the transfer of care issue which is subject to interpretation. CMS defines a transfer of care as occurring when *"…a physician or qualified NPP requests that another physician or qualified NPP take over the responsibility for managing the patients' complete care for the condition and does not expect to continue treating or caring for the patient for that condition. When this transfer is arranged, the requesting physician or qualified NPP is not asking for an opinion or advice to personally treat this patient and is not expecting to continue treating the patient for the condition."* [1]

Consultations requested by members of the same group are payable by Medicare if the consultants has expertise beyond that of the requesting physician. It should not be reported on every patient as a routine practice. The outpatient consultation codes are to be used in office, domiciliary, rest home or home settings.

Inpatient Consultations. The heading for the inpatient consult code section (99251-99255) has been revised to remove the word "initial" from the title. The guidelines for these codes have been clarified to indicate that a provider may only bill an inpatient consultation code once per patient admission. The guideline now explains that a re-request for consultation on the same patient, whether for a new problem or the same problem, and services provided to complete the initial consultation on a subsequent day must be reported using the subsequent care codes.

The verbiage used in the guideline specifies one consult per consultant per admission. Providers who bill using a group provider identification number may have problems getting reimbursed for multiple inpatient consultations performed by different providers of the same group. If a physician is covering for the physician who provided the initial consult, subsequent care should be billed for a re-request. It's unclear how a new consult provided by a different member of a group will be handled by payers. These codes are to be used for consults rendered in a hospital or nursing facility setting.

Critical Care. The bundled code listing that appears in the critical care subsection has been revised to include the new vent management codes (94002-94004) that replaced deleted codes 94656 and 94657.

Results/Testing/Reports. For the first time CPT has clarified the relationship between results, testing and what constitutes a report. This is important because many CPT descriptors include the word "report" in their definition. CPT now specifies at the beginning of each of the main sub-sections that "results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of numerous test results."[2] This further specifies that the data alone supports only the technical component of the service. The physician's interpretation allows a professional component to be billed for those services that have a professional component. Data without interpretation does not satisfy billing a professional component.

Therapeutic, Prophylactic, Diagnostic Injections and Infusions. Clarification is provided as to what constitutes incidental hydration. This is similar to the clarification that was published in CPT 2006 in the revised chemotherapy section. Now, these sections are in sync with regards to the instructions on incidental hydration. **PN**

1. Medicare Claims Processing Manual, Chapter 12, page 2.
2. CPT 2007Changes: An insiders view, AMA 2007 page 3.

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