Internal Medicine Coding Alert

CPT® 2014 Update: New E/M and Ultrasound Wound Care Therapy Codes in 2014

Good n ews: Common TCM guidelines will rid confusion while reporting transitional care.

Be prepared for changes that you need to make to your coding in 2014 — we gave you a sneak peek into some code changes coming your way in last month's issue of Internal Medicine Coding Alert — we've more in-depth insight this month, briefing you on what new codes you need to add to your coding dictionary and what new guidelines you need to incorporate into your daily practice.

Consultations Are Not Just a Thing of the Past

Effective Jan. 1, CPT® will include four new codes that describe the work of two medical professionals who discuss a patient's condition via phone or internet, as follows:

- 99446 (Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review)
- 99447 (... 11-20 minutes of medical consultative discussion and review)
- 99448 (... 21-30 minutes of medical consultative discussion and review)
- 99449 (... 31 minutes or more of medical consultative discussion and review).

"The inter-professional codes are interesting," says **Suzan Berman, MPM, CPC, CEMC, CEDC**, manager of physician compliance auditing for West Penn Allegheny Health Systems, Pittsburgh, Penn. "More and more, the provider community is communicating with patients and each other via the internet through secure email lines, etc. These codes appear to be in recognition of these situations. It affords a physician the ability to provide a virtual consultation to another physician without having the patient come to all the different appointments."

As noted, these new codes are consultative in nature, which means you must provide a written report back to the requesting physician to qualify for the code, as indicated by the phrase "including a verbal and written report" (emphasis added).

More questions: Note that these codes are time based codes. So, you'll have to base the choosing of the appropriate code depending on the amount of time that was spent for the discussion. Coders and consultants alike have many questions about these new codes. "I am a bit curious about why they are broken into time and how that time will be measured (reading, discussing, interpreting, further research, etc.).

"How will the time be documented?" Berman asks. "What will the reimbursement look like in comparison with having the patient actually come into the office?"

"The physicians will want to know if it is something they might be able to utilize," says **Chandra L. Hines**, practice supervisor of Wake Specialty Physicians in Raleigh, NC, who echoes many coders interested in determining whether insurers will include payment for these codes, since they are consultations. Keep an eye on Internal Medicine Coding Alert for more on whether these are payable once the 2014 insurance fee schedules are released.

Codify
BY AAPC

Check This New Code For Ultrasound Wound Care Therapy

If your clinician is performing the application of a low frequency ultrasound device for wound care, you had to use the Category III code 0183T (Low frequency, non-contact, non-thermal ultrasound, including topical application[s], when performed, wound assessment, and instruction[s] for ongoing care, per day) to report the procedure in 2013. In 2014, you'll be able to switch to a new Category I code, as 0183T will be deleted and no longer be valid for reporting after Jan.1.

So, for services on or after Jan.1, 2014, instead of 0183T, you'll have to report low frequency ultrasound wound care therapy using the CPT® code 97610 (Low frequency, non-contact, non-thermal ultrasound, including topical application[s], when performed, wound assessment, and instruction[s] for ongoing care, per day).

TCM Guidelines Will Match CMS in 2014

CPT® 2014 promises to work some of the kinks out of the new-in-2013 transitional care management (TCM) codes 99495 (Transitional care management services with the following required elements: Communication [direct contact, telephone, electronic] with the patient and/or caregiver within two business days of discharge, medical decision-making of at least moderate complexity during the service period, and face-to-face visit within 14 calendar days of discharge) and 99496 (...medical decision-making of high complexity during the service period, and face-to-face visit within seven calendar days of discharge).

The Editorial Panel's accepted guideline revisions will indicate that TCM services can now also apply to new patients. The 2013 guidelines limited the codes to established patients, but payers such as Medicare already allow the use of the codes for new patients, too. You'll also get clarifications about reporting discharge services and other E/M services in addition to TCM.

"Both the 2013 and 2014 guidelines state that additional E/M services after the first face-to-face may be reported separately," notes **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. "However, the 2014 guidelines make explicit that those additional E/M services must occur on subsequent dates," adds Moore.

"Also, both the 2013 and 2014 guidelines state that the same individual may report hospital or observation discharge services and TCM," says Moore. "However, the 2014 guidelines add the qualification that the discharge service may not constitute the required face-to-face visit."

Finally, the 2014 guidelines clarify that the same individual should not report TCM services provided in the postoperative period "of a service that the individual reported." "The 2013 guidelines did not include that last qualifying phrase," points out Moore. "That additional phrase makes clear that if you did not report the operative service, you may report TCM in the postoperative period," observes Moore.