Eli's Rehab Report

CPT 2001 Codes Contain Changes For Therapeutic Procedures

When the AMA announced CPT changes for 2001 this month in Chicago, physical medicine and rehabilitation (PM&R) coders were pleased to hear about new codes for botox injections, fluoroscopic guidance, therapeutic procedures and active wound-care management, as well as the addition of a new modifier. A review of the revisions indicates that most of them will make life simpler for PM&R coders.

The AMA has added some important codes and changed a lot of wording for clarification, explains **Cindy Parman, CPC, CPC-H,** co-owner of Coding Strategies Inc., an Atlanta-based billing and reimbursement firm. The new modifications outlined in CPT 2001 will take effect Jan.1, 2001, for Medicare, although it may take longer for other carriers to adopt them. Parman advises coders to work closely with carriers to determine when to begin implementing the new codes.

Therapeutic Procedure Codes

CPT 2001 lists two new therapeutic procedure codes:

97532 development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes

97533 sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes

We are very pleased that the CPT editorial panel acted to make sensory-integrative and cognitive-skills training easier to code and explain to payers, says **Judith Thomas, MGA,** director of the reimbursement and regulatory policy department for the American Occupational Therapy Association (AOTA) in Bethesda, Md. Prior to 2001, the cognitive and sensory-integrative codes existed in CPT as 97770.

CPT deleted 97770 (development of cognitive skills to improve attention, memory, problem solving, includes compensatory training and/or sensory integrative activities, direct (one-on-one) patient contact by the provider, each 15 minutes).

Thomas says that AOTA and the American Physical Therapy Association (APTA) jointly requested codes for sensory-integrative and cognitive-skills training in 1994, but only one code (97770) was introduced in CPT 1995. Having two different procedures incorporated into one code was a payment problem, Thomas says. The two procedures described in 97770 would never be used together, and, in fact, would generally be used by two different patient populations. The two procedures are separated in the new codes, making them easier to use and understand.

Code 97532 describes therapy required for adults with diagnoses of psychiatric disorders and brain injuries, Thomas says. Cognitive-skill training allows individuals with these impairments to live independently, return to work and function safely in their environments.

CPT 97533 is a technique used with pediatric patients to enhance sensory processing and promote adaptive responses to environmental demands. The techniques are used for patients suffering from conditions that cause sensory deficits, such as autism (299.0) and cerebral palsy (343.0-343.9).

Active Wound Debridement

The temporary HCPCS code, G0169 (removal of devitalized tissue, without use of anesthesia [conscious sedation, local,

regional, general]), has been replaced by two new CPT codes that AOTA and APTA jointly proposed for wound debridement:

97601 removal of devitalized tissue from wound; selective debridement, without anesthesia (e.g., high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

97602 ... non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

These procedures, which are performed to promote healing, are often used in rehabilitation facilities or by therapists who provide services to homebound or immobile patients.

New Chemodenervation Code

PM&R providers who use botulinum toxin (botox) injections to treat spastic muscle disorders will be pleased with the introduction of a new code for injections to the extremities and/or trunk muscles. Previously, there were no specific codes designated for chemodenevation to the extremities.

The new code is 64614 (chemodenervation of muscle[s]; extremity[s] and/or trunk muscle[s] [e.g., for dystonia, cerebral palsy, multiple sclerosis]). As before, the botox itself should be coded separately using J0585 for the drug.

Fluoroscopic Guidance Codes

CPT 2001 also updates guidance codes to add consistency among fluoroscopic and magnetic resonance guidance. Code 76003 will be changed to fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), which is used as fluoroscopy guidance for procedures such as vertebral biopsies (20225). A new code, 76393 (magnetic resonance guidance for needle placement [e.g., for biopsy, needle aspiration, injection, or placement of localization device], radiological supervision and interpretation) has been added to reflect the use of magnetic resonance to guide needles during procedures such as 20225 (biopsy, bone, trocar, or needle; deep [vertebral body, femur]).

Care Plan Oversight Services

Many rehabilitation physicians supervise patients in home health, hospice and nursing facility settings, and bill for these services using the care plan oversight evaluation and management (E/M) codes, 99374-99380. Physician involvement in approving home health care is a focus of the Office of Inspector Generals (OIG) 2001 work plan, so billing and coding for these services require more precision than ever before. CPT 2001 has revised the language used in these codes.

In CPT 2000, 99374 was described as physician supervision of a patient under care of a home health agency (patient not present) requiring complex and multidisciplinary care modalities ... , but CPT 2001 has expanded the descriptor to read, physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (e.g., Alzheimers facility) requiring complex and multidisciplinary care modalities ... This new descriptor gives providers more flexibility when seeking codes for patients in home-type environments, such as facilities where several paraplegic (344.1) patients live together.

Codes 99374, 99375 (physician supervision of ... home health care ... ; 30 minutes or more), 99377 physician supervision of a hospice patient; 15-29 minutes), 99378 (... 30 minutes or more), 99379 (physician supervision of a nursing facility patient, 15-29 minutes) and 99380 (... 30 minutes or more) contain new descriptor language to specify that these codes can be used for care decisions with other healthcare professionals and other non-physician professionals involved in the patients care. However, HCFA announced in its Nov. 1 Final Rule for Revisions to Payment Policies under the Physician Fee Schedule for 2001 that the revised definitions for 99375 and 99378 were not consistent with Medicare policy. Therefore, HCFA has established new, temporary HCPCS G codes to describe care plan oversight services that adopted the language from the 2000 descriptors for 99375 and 99378. Practices may be able to bill 99375 and 99378 to private insurers, but Medicare will accept only the new HCPCS codes for these services.

Note: For more information on this topic, including specifics of the new G codes, see Medicare Announces Fee Increase and New HCPCS code for 2001 on page 92.

Introduction of Modifier -60

CPT 2001 has introduced modifier -60 (altered surgical field) to use for surgical procedures that are more complex or require more time because the patient had a previous surgery resulting in infection or scarring, or other traumas that altered the surgical site.

Use modifier -60 when a surgical procedure is complicated by changes to the surgical site, making it difficult to perform the current surgical procedure. Whenever the surgeon finds that access to the patients original problem is blocked it could be due to scarring or the effects of prior surgery the surgical site has been altered, and, therefore, modifier -60 should be used, says **Susan Callaway-Stradley, CPC, CCS-P,** an independent coding consultant and educator in North Augusta, S.C.

For example, a patient underwent a bone graft (20902) 10 years ago and is now in a rehab facility for a stroke (436).The attending rehabilitation physician attempts a simple removal of a foreign body in a muscle (20520), but the patients prior bone graft caused excessive scarring, complicating the foreign body removal. The physician could add modifier -60 to 20520 to indicate that the surgical field was altered by the patients prior surgery.

Modifier -60 was introduced to clarify the broad descriptor that previously existed for modifier -22 (unusual procedural services). The descriptor for modifier -22 has been amended:

When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier -22 to the usual procedure number or by the use of the separate five-digit modifier 09922. A report may also be appropriate. **Note:** This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior surgery, irradiation, infection, very low weight, or trauma.(See modifier -60 as appropriate.)

In the previous example, if the rehab physician attempted the foreign body removal and the patient began bleeding excessively, requiring additional time to perform the procedure, the physician would append modifier -22 to 20520 to indicate that the procedure was unusually complicated, but not because of an altered surgical field.

As with modifier -22, any claims using modifier -60 should include a note with the claim explaining why the procedure was more complex than usual. Also include the increase in the amount charged, because insurers will not increase payment just because the modifier was attached to the claim.