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RECENT CHANGES TO CPT CODING

The AMA CPT Editorial Panel made a number of changes to CPT coding for 2006 and 2008 that are relevant to psychiatrists. We encourage all psychiatrists to purchase a copy of the AMA CPT manual each year in order to remain current with CPT coding and documentation requirements. Copies can be obtained by calling 800-621-8335. APA members with specific CPT coding questions should put them in writing and email (hsf@psych.org) or fax (703-907-1089) them to APA's Office of Healthcare Systems and Financing for review by APA's CPT Coding Network.

Please note that the existence of a CPT code does not guarantee payment of the described service; payment policies are established by individual payers.

Changes Made in 2006

Psychiatry Section

90871 – ECT multiple seizure. This code was deleted at the request of the APA. All visits for ECT should now be coded using CPT code 90870.

0018T – Delivery of high power, focal magnetic pulses for direct stimulation to cortical neurons. A parenthetical note was added regarding coding for repetitive transcranial magnetic stimulation (rTMS) for treatment of clinical depression. CPT now directs clinicians to use Category III code 0018T.

95970, 95974, and 95975 – Neurostimulators, Analysis–Programming. The CPT Editorial Panel approved coding for vagus nerve stimulation (VNS) therapy for treatment-resistant depression. Clinicians performing VNS therapy should use codes 95970, 95974, and 95975 found in the neurology subsection of the CPT manual. A parenthetical to this effect will appear in the 2007 edition of the AMA CPT publication.

Evaluation and Management Section

Consultations

New descriptive language has also been added to CPT in an effort to better define the use of the consultation codes.

- Consultations that are requested by a physician or other appropriate source should be noted in the patient's written record; the consulting physician should also provide a written report of findings back to the requesting entity. In this instance the appropriate consultation CPT code should be used.

- A consultation initiated at the request of patient or family should not be reported using the consultation codes but rather the appropriate office visit codes.
- Mandated consultations (e.g., third-party payers) should be reported using the consultation codes along with modifier 32.
- If following the consultation the clinician assumes responsibility for the management of a portion or all of the patient's condition, the appropriate evaluation and management services code should be used after the initial consult.

99261–99263 – Follow-up inpatient consult codes. These codes were deleted from CPT. Instead clinicians should use the appropriate code from one of the following groups:

- For follow-up inpatient consultations see 99231–99233, Subsequent Care Codes in the Inpatient Setting.
- For follow-up consultations in a nursing facility see 99307–99310, Subsequent Nursing Facility Care

99311–99313 – Subsequent nursing facility care codes. These codes were deleted and replaced by the following new codes: **99307– 99310**.

There are now four levels of care rather than the previous three levels of care. Note that there are no typical unit times for the new subsequent care codes for nursing facilities. The AMA CPT Editorial Panel has sent these codes to the AMA RVS Update Committee to be valued and have the times assigned. APA has asked CPT for a status report and for recommendations we can share with our members in those instances when time is supposed to drive the choice (when more than 50% of the visit is spent on counseling and coordination of care). Until those recommendations from the AMA are received code selection should be based on the descriptors below.

New codes: These codes are the new subsequent nursing facility care codes.

99307 – Subsequent nursing facility care, per day, for the evaluation and management of a patient. Requires at least two of these three key components: 1. Problem focused interval history, 2. Problem focused exam, 3. Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient is stable, recovering, or improving.

99308 – Subsequent nursing facility care, per day, for the evaluation and management of a patient. Requires at least two of these three key components: 1. Expanded problem focused interval history, 2. Expanded problem focused exam, 3. Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication.

99309 – Subsequent nursing facility care, per day, for the evaluation and management of a patient. Requires at least two of these three key components: 1. Detailed interval history, 2. Detailed exam, 3. Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or significant new problem.

99310 – Subsequent nursing facility care, per day, for the evaluation and management of a patient. Requires at least two of these three key components: 1. Comprehensive interval history, 2. Comprehensive exam, 3. Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient is unstable or has developed a significant new problem requiring immediate physician attention.

Central Nervous System Assessments/Tests Section

There have also been extensive changes to the section on Central Nervous System Assessments/Tests (**96100 – 96120**) which are not included in this document. See AMA's 2006 CPT manual for complete details.

Changes made in 2008

Evaluation and Management Section

Subsequent nursing facility care codes: In 2006 the subsequent nursing facility care codes (99311–99313) were deleted and replaced by codes 99307– 99310. For 2008 the AMA CPT Editorial Panel has since established the typical times as described below.

99307 – Subsequent nursing facility care, per day, for the evaluation and management of a patient. Problem focused interval history. Physicians typically spend 10 minutes with the patient and/or family or caregiver.

99308 – Subsequent nursing facility care, per day, for the evaluation and management of a patient. Expanded problem focused interval history. Physicians typically spend 15 minutes with the patient and/or family or caregiver.

99309 – Subsequent nursing facility care, per day, for the evaluation and management of a patient. Detailed interval history. Physicians typically spend 25 minutes with the patient and/or family or caregiver.

99310 – Subsequent nursing facility care, per day, for the evaluation and management of a patient. Comprehensive interval history. Physicians typically spend 35 minutes with the patient and/or family or caregiver.

Medical Team Conferences: Codes describing medical team conferences with face-to-face participation by three or more qualified health care professionals from different specialties or disciplines were added. Only one of them is for physicians:

99366 – Medical team conference, with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional (physicians should report the appropriate Evaluation and Management service code for this service)

99367 – Medical team conference, with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician

Preventive Medicine Services: New codes for preventive care and health promotion.

Behavior Change Interventions, Individual

99406 – Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407 – Intensive, greater than 10 minutes (Do not report 99407 with 99406)

99408 – Alcohol and/or substance (other than tobacco abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes (Do not report services of less than 15 minutes with 99408). When billing Medicare for this service use G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention, 15 to 30 minutes)

99409 – Greater than 30 minutes (Do not report 99409 in conjunction with 99408). When billing Medicare for this service use G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention greater than 30 minutes)

(Use 99408 and 99409 only for the initial screening and brief intervention)

Non-Face-to-Face Physician Services:

New codes describing services provided by telephone and email

Telephone Evaluation and Management Service

99441 – Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion

99442 – 11–20 minutes of medical discussion

99443 – 21–30 minutes of medical discussion

(Do not report 99441–99443 when using 99339–99340, 99374–99380 for the same call)

On-Line Medical Evaluation

99444 – Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network.

(Do not report 99444 when using 99339–99340, 99374–99380 for the same communication)