Evaluation and Management Services:

Eliminating “providers” and “physicians” from Evaluation and Management code descriptors

Previous to the 2013 CPT Changes, Evaluation and Management codes had the following descriptions: “Counseling and/or coordination of care with providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.” This has now been changed to “Counseling and/or coordination of care with other physicians, qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.” This provides a more definitive description of what constitutes a “provider” from a CPT standpoint.

The previous verbiage was also followed by a time threshold with the following language, “Physicians typically spend (amount of time) face-to-face with the patient and/or family.” This has now been changed to “Typically (amount of time) are spent face-to-face with the patient and/or family.”

Defining the broad term “Counseling”

Counseling is now defined as: “a discussion with a patient and/or family concerning one or more of the following: Diagnostic results, impressions, and/or recommended diagnostic studies, Prognosis, Risks and benefits of management (treatment) options, Instructions for management (treatment) and/or follow-up, Importance of compliance with chosen management (treatment) option, Risk factor reduction, and Patient and family education”. Again, more definition provided at what may take place in a counseling session. A discussion with a patient in which treatment options, etc and the risks/benefits of those options, would fall under the counseling definition.

Complex Chronic Care Coordination Services:

Codes 99487-99489 are reported once per calendar month; include all non-face-to-face CCCC services; include none or 1 face-to-face office or other outpatient, home, or domiciliary visit; and may only be reported by the single physician or other QHP who assumes the care coordination role with a particular patient for the calendar month.

Time of care coordination with the emergency department is reportable using 99487-99489, but time while the patient is inpatient or admitted as observation is not.

If the physician personally performs the clinical staff activities, his or her time may be counted toward the required clinical staff time to meet the elements of the code.

Additional E/M services beyond the first visit may be reported separately by the same physician or other QHP during the same calendar month.

99487 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

99488 Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month

99489 Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

Transitional Care Management Services:

Codes 99495, 99496 require: –A face-to-face visit within the specified time frames;–Interactive contact with the patient or caregiver within 2 business days of discharge and may be direct (face-to-face), telephonic, or by electronic means; –Medication reconciliation and management no later than the date of the face-to-face visit
If another individual provides TCM services within the postoperative period of a surgical package, modifier 54 is not required.

The required contact with the patient or caregiver, as appropriate, may be by the physician or qualified health care professional or clinical staff. Within two business days of discharge is Monday through Friday except holidays without respect to normal practice hours or date of notification of discharge. The contact must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care. If two or more separate attempts are made in a timely manner, but are unsuccessful and other transitional care management criteria are met, the service may be reported.

99495 Transitional care management services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge

99496 Transitional care management services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period face-to-face visit, within 7 calendar days of discharge

Transition of patient to hospice, long-term care, home care, all meet the criteria for use of the above codes.

**Nerve Conduction Tests:**

CPT codes 95900, 95903, 95904, and H-reflex codes 95934 and 95936 have been deleted.

Guideline instruction explains how to report the codes for the purposes of billing. A single conduction study is defined as a sensory conduction test, a motor conduction test with or without an F wave test, or an H-reflex test. Each type of study (sensory, motor with or without F wave, H-reflex) for each nerve includes all orthodromic and antidromic impulses associated with that nerve and constitutes a distinct study when determining the number of studies in each grouping (eg, 1–2 or 3–4 nerve conduction studies). Each type of nerve conduction study is counted only once when multiple sites on the same nerve are stimulated or recorded. The following codes indicate the number of nerve conduction studies performed, whereas in previous CPT, the codes 95900 - 95904 the unit of service was each nerve. For coding purposes, a single conduction study would be a sensory conduction test, a motor conduction test with or without an F-wave test, or an H-reflex test. Each type of study is counted only once when multiple sites on the same nerve are stimulated or recorded. The numbers of these separate tests would be added to determine which code should be assigned.

95907 Nerve conduction studies; 1-2 studies

95908 Nerve conduction studies; 3-4 studies

95909 Nerve conduction studies; 5-6 studies

95910 Nerve conduction studies; 7-8 studies

95911 Nerve conduction studies; 9-10 studies

95912 Nerve conduction studies; 11-12 studies

95913 Nerve conduction studies; 13 or more studies

95924 Ans parasymp & symp w/tilt

95943 Parasymp&symp hrt rate test
2013 CPT Changes-Neurology

Intraoperative Neurophysiology:
Code 95920 has been deleted.
+95940 Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes
   New code 95940 is reported per 15 minutes of service and requires reporting only the portion of time the monitoring professional was physically present in the operating room providing one-on-one patient monitoring, and no other cases may be monitored at the same time.
+95941 Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour.
   New code 95941 is reported for all cases in which there was no physical presence by the monitoring professional in the operating room during the monitoring time or when monitoring more than one case while in an operating room.

These new codes are add-on codes and are used in conjunction with the study performed. The differentiation between the two is physical presence of the monitoring physician.

G0453 Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)

Chemodenervation for Chronic Migraine
64615 Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)

Pediatric Polysomnography
Two new codes (95782, 95783) have been created to report pediatric polysomnography for children younger than 6 years of age. These patients are typically monitored for a longer period of time than adults (on average 9 hours) and typically require a 1:1 technologist to patient ratio. Pediatric studies tend to be more complex to review due to longer recordings and more data. Therefore, code 95808 now reads “any age” and codes 95810 and 95811 have been changed to read “age 6 years or older.”

95782 Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

95783 Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist.

Autonomic Function Tests
New code 95924 has been created for reporting circumstances when both parasympathetic (92921) and adrenergic function (92922) types of autonomic testing are performed together. It includes tilt table use.

95924 - combined parasympathetic and sympathetic adrenergic testing with at least 5 minutes of passive tilt (do not report with 95921 or 95922)

New code 95943 has been created to report when an autonomic function testing does not include beat-to-beat recording, or when testing without the use of a tilt table. This is a simpler, automated procedure compared to the other automated codes.

95943 - Simultaneous, independent, quantitative measures of both parasympathetic and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change. Do not report with 93040, 95921, 95922, 95924.