Get Familiar with Seven Key CPT Changes for 2006

Changes implemented this year can have a big impact on dermatology practices. Here are points to keep in mind regarding seven changes.

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Each year, the new edition of CPT brings changes. For 2006 there are a few notable updates that will affect the way dermatologists code for services. The following is a rundown of seven key changes that may influence you in your practice. Be sure to refer to the CPT text for additional details.

1. Modifier 25. One of the most notable changes for 2006 is an addition to the definition of modifier 25. "A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported…" The Office of Inspector General, as well as carriers, often monitors this modifier. To ensure that your documentation is appropriate, consider this long-standing, straight-forward advice: make certain that if you were to remove the surgery documentation from your record, the remaining documentation of the E/M service would support the E/M code you have chosen.

2. Codes 99261-99263. The codes for follow-up inpatient consultations (99261-99263) have been deleted. Now, you should report these services using "Subsequent Hospital Care" codes, 99231-99233.

There are new codes for use if the patient is in a nursing facility. These are the "Subsequent Nursing Facility Care" codes, 99307-99310.

3. "Confirmatory Consultation." Also deleted are the codes for "Confirmatory Consultation." Instead of a confirmatory consultation code, choose the appropriate E/M code for the setting and type of service. Some clinicians have been confused about the nature of a "consultation." Added to the definition of Consultation for 2006 is the phrase "a consultation initiated by a patient and/or family and not requested by a physician, is not reported using the consultation codes but may be reported using the office visit codes, as appropriate."

4. Codes 99304-99340. All E/M codes for Nursing Facility and Domiciliary Facility visits have been changed. See CPT 2006 for codes numbered 99304-99340.

5. Graft codes. There are numerous changes and new codes related to skingrafts, autografts, tissue cultured autografts, acellular dermal replacements, allografts, and xenografts. These are codes starting with "15;" review this section of CPT to see the updates.

6. Codes 64650, 64653. Two new codes have been introduced for chemodenervation of eccrine glands that should be used to code the treatment of hyperhidrosis with Botox®. These are 64650 "Chemodenervation of eccrine glands; both axillae." And 64653 "other areas (e.g. Scalp, face, neck) per day." For full reimbursement, be sure to code the Botox® separately using the J-code, J0585.

Medicare Reimbursement Update

1. Congress is expected to keep Medicare physician reimbursements at the 2005 level rather than implement the 4.4 percent reduction dictated by the sustainable growth rate formula. CMS has instructed carriers to begin paying claims at the 2005 rate within two business days of enactment of the bill, which should take place in February.

2. For claims already processed at the 4.4 percent reduction between January 1 and the passage of the bill, carriers will automatically reprocess the claims and pay lump sum amounts to the physicians, meaning that practices will not have to resubmit claims.

3. There will be an additional Physician enrollment period during which physicians may change participation status. Any changes in status will be retroactive to January 1, 2006.

7. New codes for drug administration. 90782 (IM or SQ injection, therapeutic, prophylactic, or diagnostic) and 90788 (IM injection of antibiotic) are out and have been replaced by 90772, "Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular."

96400 (chemotherapy administration, SQ or IM) has been replaced by 96401, "Chemotherapy administration, subcutaneous or intramuscular; nonhormonal anti-neoplastic," and 96402, "hormonal antineoplastic."

Slight changes have been made in the wording of the definitions for 96405 and 96406, but they essentially remain the same in use. The updated terminology includes: 96405 "Chemotherapy administration; intralesional, up to and including seven lesions." 96406 "intralesional, more than seven lesions."

For infusions, 96410 and 96412 (Chemotherapy administration, IV technique) have been deleted. The new codes are 96413,"Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug," and 96415, "each additional hour, one to eight hours (list separately in addition to code for primary procedure.)" Use the new codes, 96413 and 96415, for infusion of Remicade, and remember the J-code (J1745).

With any of the above drug administration codes, be sure to include the appropriate J codes for all medications injected or infused. If you provide other types of infusion, see the appropriate sections of CPT for any updates; codes numbered 90281-90779 and 96401-96549.