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## 2006 CHANGES TO CPT CODING

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The AMA CPT Editorial Panel made a number of changes to CPT coding for 2006 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 regard to 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](mailto: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.

### 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.

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- 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.