

# New Codes in Place for Injections, Education

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CHICAGO — Make yourself aware of the new endocrinology diagnosis and procedure codes for this year, Dr. S. Sethu K. Reddy advised at the annual meeting of the American Association of Clinical Endocrinologists.

An important change is that the CPT code for “therapeutic, prophylactic, or diagnostic injection” is now 90772; it used to be 90872, said Dr. Reddy, chairman of coding and reimbursement for AACE. The G-code for a therapeutic or diagnostic injection, either subcutaneous or intramuscular, has been changed from G0351 to a C-code, C-8952, he said.

In addition, there are some important changes to the ICD-9 codes, said Dr. Reddy, chairman of the endocrinology, diabetes, and metabolism department at the Cleveland Clinic. For example, there is a new code, 259.5, for androgen insensitivity syndrome, and another new code, 276.50, for volume depletion of an unspecified nature; that code was expanded from 276.5 to add a fifth digit. There is also a third new code, 278.02, for overweight, he said.

New V codes include V15.88 for history of fall, V17.81 for family history of osteoporosis, and V26.31 for genetic disease carrier status testing. There is also a series of V codes related to weight: V85.0 for a body mass index (BMI) of less than 19 kg/m<sup>2</sup>, V85.1 for BMI from 19.1 to 24.9, V85.2 for BMI of 25-29, and so on up to V85.4 for BMI of 40 and over. All codes for BMI of between 25 and 39 require a fifth digit for specificity—for example, the code for a BMI of 27.0 to 27.9 is V85.23. “V-codes are not really for payment; they are meant for documentation,” he reminded the audience.

Coding for diabetes education is also

changing, according to Dr. Reddy. For instance, the Centers for Medicare and Medicaid Services will no longer pay for G108 (diabetes outpatient self-management training services, individual, per 30 minutes) or G109 (diabetes self-management training services, group session [two or more], per 30 minutes) codes if a registered nurse is doing the training; instead, the trainer must be a certified diabetes educator.

“If the [trainer] is not a certified diabetes educator, you may end up having to use a level 1 nurse visit,” he warned.

There is one exception to that rule: If the education program is being done by a hospital in a dedicated education room and is certified by the American Diabetes Association, registered nurses may be used as trainers, he said. The failure to include office-based practices in this exemption “is taking many office-based endocrinologists out of the loop of patient education.”

AACE also has been working on getting a code for insulin pump training, Dr. Reddy said. “We applied for a code for insulin pump training about 3 years ago. It was changed to an intensive insulin therapy code, and it finally evolved into an educational training or patient self-management code.” The advantage of this code, which is new this year, is that it can be used for other disorders such as asthma and osteoporosis.

The code for “education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family), each 30 minutes, individual patient” is 98960. There are also codes 98961 for groups of 2-4 patients and 98962 for groups of 5-8 patients. “The challenge is for AACE to develop standardized curriculum with a pretest and a posttest, and foster political support for coverage,” he said. ■

## Infusions Can Be Profitable Despite Low Medicare Rates

WASHINGTON — In spite of poor Medicare reimbursement, infusion therapy can still be profitable, Steven M. Coplon said at a conference sponsored by Elsevier Oncology.

Under Medicare’s reimbursement system for infusion drugs, “essential services are underreimbursed or not reimbursed,” said Mr. Coplon, chief executive officer of The West Clinic, a Memphis, Tenn., oncology practice. “But the cost of drugs, staff, facilities, and malpractice insurance all continue to increase.”

Practices have to look more closely at the revenue they are getting for their services, Mr. Coplon said. For example, “on one drug regimen [given frequently to Medicare patients], we’re making \$24 on \$7,061 worth of investment.”

One way to increase revenue is to increase the amount the practice brings in from private payers, he continued.

“Negotiate it to the best of your ability; go for every code you can possibly think of,” he advised. “If they’re willing to say yes, you can make up for a lot of these margins you’re losing on Medicare.”

Roberta L. Buell, vice president of provider services and reimbursement at P4 Healthcare, Sausalito, Calif., encouraged optimal billing procedures: “80% of receivables should be less than 90 days overdue,” said Ms. Buell. “And if your practice is more than 50% Medicare, you should be doing much better than that.”

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## POLICY & PRACTICE

### NIDDK Director Search Continues

The application deadline has come and gone for the position of director of the National Institute of Diabetes and Digestive and Kidney Diseases. The last director of the institute, Dr. Allen M. Spiegel, left in March to become dean of the Albert Einstein College of Medicine in New York. Dr. Spiegel became director of the institute in 1999; Dr. Griffin Rodgers is serving as acting director until a new director is found. Dr. Spiegel will be sorely missed, according to Dr. Elias Zerhouni, director of the National Institutes of Health. “Allen Spiegel does whatever he does with grace, insight, and an analytical mind,” Dr. Zerhouni said at Dr. Spiegel’s farewell reception. “He has the highest degree of intellectual rigor and integrity of anyone I’ve met.” Applications for the director’s job were due July 31; the agency expects to begin reviewing and rating candidates this month, a spokeswoman said.

### Report Faults Wound Payment

Medicare needs to improve the way it pays for wound management, according to a new report by AdvaMed, a trade association for medical device companies. “Coverage and reimbursement policies in the nation’s Medicare system currently do not reflect technological advances in wound care management, are too comprehensive, and can cause disruptions in delivering appropriate care to patients,” the report’s authors said. “Medicare often focuses narrowly on a specific unit cost or the cost of wound care at a specific site, while not considering the long-term costs of caring for patients.” AdvaMed urged the Centers for Medicare and Medicaid Services (CMS) to increase the amount of money the agency pays for wound care supplies used by hospitals, nursing homes, and outpatient clinics. The group also recommended that CMS “revise the [payment] for skilled nursing facilities to reflect the incremental cost for the necessary treatment and therapy of a wound when it is not the primary diagnosis.” The recommendations also included prevention: AdvaMed suggested the agency provide coverage as part of Medicare’s surgical dressing benefit for “preventive and early intervention technologies for tissue damage.”

### Diabetes Guide for Schools

The Department of Health and Human Services has released a guide to help school personnel, parents, and students manage diabetes in the school setting. “Studies show diabetes management and control can help prevent or delay diabetes-related complications,” the department noted in a press release. “However, students with diabetes need a supportive environment to help them take care of their diabetes through the school day during school-sponsored activities.” The guide includes a diabetes primer, copier-ready action plans, and a review of school re-

sponsibilities under federal laws. It is available from the department’s National Diabetes Education Program at [www.ndep.nih.gov/resources/school.htm](http://www.ndep.nih.gov/resources/school.htm) or by calling 800-438-5383.

### Postmarketing Follow-Up

The Food and Drug Administration is doing a poor job of ensuring that pharmaceutical companies live up to postmarketing study commitments, according to a new report by the Department of Health and Human Services’ Office of Inspector General (OIG). Among the findings: that the FDA can’t easily identify if the studies are progressing or what stage they are in; and that monitoring postmarketing studies “is not a top priority at FDA.” The OIG reviewed new drug applications from 1990-2004; 48% of those applications had at least one postmarketing study commitment. Drug makers are required to submit annual status reports. The OIG found that 35% of the reports that should have been submitted in fiscal 2004 were missing or had no information on the study commitments. Even complete reports provide limited useful information, and on top of that, the FDA’s information system for monitoring those reports doesn’t glean much, either, said the OIG. The Office noted that the FDA has limited enforcement power in this area, but suggested that the agency require more, and more relevant, information from drug makers in the reports. In a response to the OIG, the agency said it could not do that without additional regulations, but agreed that it needed to do more to improve its monitoring and to ensure that commitments are honored and that annual reports are thorough.

### Rhode Island Health Care Bills

Rhode Island Governor Donald L. Carcieri (R) signed legislation in early July to address rising health insurance costs and the uninsured problem in the state. One bill creates a reinsurance program to help pay the health insurance premiums for low- and moderate-income wage earners, as well as to help low-wage small businesses pay health insurance costs. Another bill creates a new benefit plan for individual policyholders and businesses with 50 or fewer workers. The plan will have a target cost of 90% of the standard plan premium or, in the case of individual insurance, no more than 10% of the total statewide average wage. A third bill will expand the current state reports on the quality of hospital care to also include community-based care, and will link the quality data to cost data “As long as health care costs continue to grow, there are going to be ways we can work to improve the system to help Rhode Islanders get the health care they need at a price they can afford,” said state Rep. Steven Costantino (D-Providence), cochair of the state legislature’s Joint Committee on Health Care Oversight, which developed some of the bills.