What’s New for 2009?

- CODES: New CPT/ICD Codes
- VALUE-RBRVS: New RVU’s and CF
- PAYER PAYMENT:
  - AAP Private Sector Advocacy Program
  - State Pediatric Councils
  - National Class Action Law Suits
- PATIENTS:
  - Covered Benefit
  - Consumer Driven Health Care
- YOUR CONTRACT: Pay for Performance

IMPORTANCE OF ACCURATE, APPROPRIATE CODING

- INCREASED PAYMENT
- DECREASED LIABILITY
- IMPROVED INFORMATION FLOW
Increase Revenue
Production
  Increase volume of patients seen
Management
  Decrease costs
  Increase efficiencies
Contracts
  Increase contractual fee reimbursement
Procedures
  Provide and code for procedures
Coding
  Code correctly for services rendered
  Relative increase in production

Decrease Liability
Accountability for Business Practices
  HIPAA
Coding
  Documentation
  Compliance
  Audits
Fraud and Abuse

Encounter Based Information
You Can’t Manage What You Can’t Measure!
Internal
  Evaluate capitation contracts
  Income division / bonuses
External
  Track and demonstrate provider value
  Pay for Performance (P4P)
  Outcome & Quality measures are CPT & ICD derived
Increase Payment and Decrease Liability Through Physician Knowledge and Use of Coding

Increase revenues by increasing productivity without working harder!

Basic Coding Systems

HCPCS: Complete coding system for all services furnished
Healthcare Common Procedural Coding System

CPT: Coding for services furnished
Current Procedural Terminology

ICD-9-CM: Coding for diagnosis/reason for services
International Classification of Diseases, 9th
Revision Clinical Modification

RBRVS: Assigns a relative payment for CPT codes
Resource Based Relative Value Scale

Diagnosis Codes: ICD-9-CM

- International Classification of Diseases, 9th
  Revision, Clinical Modification
- Become effective on October 1st of every year
- Different rules for outpatient and inpatient encounters
- Diagnosis listed on an encounter form (superbill), must be documented in visit record
Using and Reporting ICD-9-CM Codes

Code to the highest degree of specificity
Code to the highest degree of certainty for the encounter such as symptoms, signs, abnormal test results
Probable, suspected, questionable, or rule out should not be coded
List the ICD-9-CM code that is identified as the main reason for the service first. Next list any current coexisting conditions.
Chronic disease treated on an ongoing basis may be coded
Do not code for conditions that were previously treated and no longer exist

V - Codes

• V 04.0 to V 06.9 Vaccines
• V 20.2 Well Infant / Child
• V 65.11 Conference with Parent
• V 65.19 Ped Prebirth Visit Expectant Mother
• V 65.5 Feared Illness / None Found
• V 67.9 Follow up Exam
• V 67.59 Follow up after Rx
• V 72.84 Preoperative Exam

V 67.59 Follow up Exam

Ex: Options for Follow up Otitis Media
1. 382.00 Otitis Media, Acute, Purulent
   V 67.59 Follow up after Rx
2. V 67.59 Follow up after Rx
   382.00 Otitis Media, Acute, Purulent
3. V 67.59 Follow up after Rx
4. 382.00 Otitis Media, Acute, Purulent
What if nothing’s wrong?

- When unable to find specific conditions then code for “Exam (observation) for”:
  - following accident (V71.4)
  - for work (school) related incident (V71.3)
  - for alleged assault (V71.6)
  - for alleged rape or sexual assault (V71.5)
  - for suspected abuse or neglect (V71.81)
  - for other suspected condition (V71.89)

New Codes and Recent Additions

- 276.52 Hypovolemia
- 278.02 Overweight
- Asthma
  - 493.81 Exercise-induced bronchospasm
  - 493.82 Cough variant asthma
- 780.91 Fussy infant (baby)
- 780.92 Excessive crying of infant (baby)
- 780.95 Excessive crying, child adolescent, adult
- 799.02 Hypoxemia

ICD Changes for 2006

- V64.00 Vaccination not carried out
  - V64.01 Acute illness
  - V64.02 Chronic illness
  - V64.03 Immune compromised state
  - V64.04 Allergy to vaccine
  - V64.05 Caregiver refusal
  - V64.06 Patient refusal
  - V64.07 Religious reasons
  - V64.08 Had disease being vaccinated against
ICD Changes for 2007

- 519.11 Acute bronchospasm
- 780.32 Complex febrile convulsions
- 780.95 Febrile convulsions (simple), unspecified

ICD Changes for 2007

- V58.30 Change or removal of nonsurgical wound dressing
- V58.31 Change or removal of surgical wound dressing
- V58.32 Removal of sutures (staples)
- V72.11 Hearing examination following failed hearing screening
- V82.71 Screening for genetic disease carrier state

ICD Changes for 2007

- V85.51 Body Mass Index, pediatric
  Less than 5th percentile for age
- V85.52 5th to less than 85th percentile for age
- V85.53 85th to less than 95th percentile for age
- V85.54 Greater than or equal to 95th percentile for age
ICD 2008

• Effective and must be accepted on October 1, 2007
• New code infant botulism
• New code speech and language delay due to hearing loss
• New and revised codes hearing loss
• New codes herpes 6 and 7 infections
• New and revised codes dysphagia
• Expansion codes related to family history

ICD Changes for 2009
Effective October 1, 2008

• 046.79 – 059.9 Orthopoxvirus infections
  Poxvirus infections
• 078.12 Plantar wart
• 203.02 - 208.90 Malignancies in relapse
  Multiple myeloma
  Leukemias
• 611.8 Other specified disorders of breast

ICD Changes for 2009
MRSA

• 038.12 MRSA septicemia
• 041.12 MRSA classified elsewhere, unspecified site
• V02.53 Carrier (or suspected) MSSA
• V02.54 Carrier (or suspected) MRSA
• V12.04 Personal Hx MRSA
ICD Changes for 2009
Fever

- 780.60 Fever, unspecified
- 780.61 Fever, presenting with conditions classified elsewhere
- 780.62 Post procedural fever
- 780.63 Post vaccination fever
- 780.64 Chills (without fever)
- 780.65 Hypothermia (nl environmental temp)

ICD Changes for 2009
Headaches

- 339.00 Cluster HA syndrome, unspecified
- 339.01 Episodic cluster HA
- 339.02 Chronic cluster HA
- 339.10 Tension HA, unspecified
- 339.11 Episodic tension HA
- 339.12 Chronic tension HA

ICD Changes for 2009
Headaches

- 339.20 Post-traumatic HA, unspecified
- 339.21 Acute post-traumatic HA
- 339.22 Chronic post-traumatic HA
- 339.42 New daily persistent HA
ICD Changes for 2009

**Headaches**

- **339.44**  
  Other complicated HA syndrome
- **346.00-346.91**  
  Migraine headaches  
  - With and w/o **aura**  
  - With and w/o **status migrainosus**  
  - With and w/o **intractable**  
  - Variants of migraine  
  - Hemiplegic migraine  
  - Menstrual migraine  
  - With and w/o cerebral infarction  
  - Other forms of migraine

**ICD Changes for 2009**

**Effective October 1, 2008**

- **V 28.8** Encounter for other specified antenatal screening
- **V 61.01 – 61.09** Family disruption  
  - Military deployment  
  - Return from military deployment  
  - Divorce or legal separation  
  - Parent-Child estrangement  
  - Child in welfare custody  
  - Foster care or non-parental family
- **V 62.2** Other occupational circumstances or maladjustment

**ICD Changes for 2010**

**Effective October 1, 2009**

**New Codes**

- **756.72** Omphalocele
- **756.73** Gastrochisis
- **768.70** Hypoxic-ischemic encephalopathy, unspecified
- **768.71** Mild
- **768.72** Moderate
- **768.73** Severe
### ICD Changes for 2010

**Effective October 1, 2009**

**New Codes**

- 779.31 Feeding problems in newborn
- 779.32 Bilious vomiting newborn
- 779.32 Other vomiting in newborn
- 779.34 Failure to thrive in newborn
- 789.7 Colic
- 799.82 Apparent life threatening event in infant

### ICD Changes for 2010

**Effective October 1, 2009**

**New Codes**

- 799.21 Nervousness
- 799.22 Irritability
- 799.23 Impulsiveness
- 799.24 Emotional Lability
- 832.2 Nursemaid’s elbow

### ICD Changes for 2010

**Effective October 1, 2009**

**New V Codes**

- V15.83 Personal history of under immunization status
- V20.31 Health supervision for newborn under 8 days
- V20.32 Health supervision for newborn 8 to 28 days
- V60.81 Foster care (status)
ICD Changes for 2010
Effective October 1, 2009
New V Codes

- Family disruption code additions
  - V61.97 Due to death of family member
  - V61.08 Due to other extended absence of family member
- V61.23 Counseling for parent-biologic child problem
- V61.24 Counseling for parent-adopted child problem
- V61.25 Counseling for parent/guardian foster child problem
- V61.42 Substance abuse in family

ICD Changes for 2010
Effective October 1, 2009
New V Codes

- V80.01 Special screening for traumatic brain injury
- V80.09 Special screening for other neurological condition
- V87.44 Personal history of inhaled steroid therapy
- V87.45 Personal history of systemic steroid therapy
- V87.46 Personal history of immunosuppressive therapy

Is it covered?
“Medical Necessity”

- The discharge diagnoses should account for provided services and testing
- An x-ray may not be considered justified if the diagnosis is “cold” (460)
- Supplementary diagnosis of abnormal breath sound (786.7), fever (780.6), pneumonia (486) could be used as justification for the x-ray
AAP ICD-9 Coding Flipchart

- User friendly format
- Annually updated

Current Procedural Terminology

Guidelines and procedures listed by separate sections
- Evaluation/Management
- Anesthesiology
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine

All physicians may code from any section where services are found.
Higher relative values are in the procedural sections!

CPT Coding

Ten Basic Principles of Use

1. Physician should select diagnosis and procedure codes
   Coding confirmed by the “coding team”

2. Document patient services to support codes
   Good Care and Compliance

3. Use separate codes for different encounters
**Office Visit Revenue / Year**

<table>
<thead>
<tr>
<th>Est OV Code</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>Total Charges</th>
</tr>
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<tbody>
<tr>
<td>OV Charge</td>
<td>$35</td>
<td>$50</td>
<td>$80</td>
<td>$202,500</td>
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<tr>
<td>Under Coding</td>
<td>2500 visits</td>
<td>1500</td>
<td>500</td>
<td>$33,750</td>
</tr>
<tr>
<td>Expected Coding</td>
<td>750 visits</td>
<td>3000</td>
<td>750</td>
<td>$236,250</td>
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<tr>
<td>Over Coding</td>
<td>500 visits</td>
<td>1500</td>
<td>2500</td>
<td>$292,500</td>
</tr>
</tbody>
</table>

Total $ Difference

- Over Coding: $56,250
- Expected Coding: $87,500
- Under Coding: $35,750
CPT Coding
Ten Basic Principles of Use

1. Physician should select diagnosis and procedure codes
   Coding confirmed by the “coding team”

2. Document patient services to support codes
   Good care and Compliance

3. Use separate codes for different encounters

4. Set a separate fee for each code
   Consider the RBRVS

5. Learn to use modifiers, procedure, and add-on codes

6. Set fees independent of payments

7. Know local variations in payments
   Payment policies of payers – Use in contracting

8. Inquire about lowered or changed payments
   Watch your EOB’s – Denial management
   APPEAL! APPEAL! APPEAL!

9. Review your codes and fees regularly

10. Design a superbill/computerized routing sheet

Auditing / Documentation

- 95, 97 Guidelines
- Code to meet your documentation
- If it’s not in the chart, it wasn’t done
- Address handwriting, required signatures
- Dictate (look for evidence of physician review)
- Templates / Clinical forms
- Computer assists: Electronic medical records
- Beware of “Documentation Upcoding”
  Must be medically necessary!
Audit Friendly Charting

- Vital Signs (3 of Ht Wt BP RR HR Temp)
- SOAP format
- CC: Chief Complaint
- HPI: History of Present Illness
- PFSH: Past, Family, Social History
- ROS: Review of Systems
- Impression/Plan (Medical Decision Making)
  - DDx, Tests, Treatment, Prescriptions
  - Counseling/Coordination of Care
- Time - Note time of encounter
  Total Time/Time Counseling-Coordinating care
  T/C ex: T25/ C15

Self Auditing

- Periodic internal chart reviews
- Retrospective
  - Palm Pilot
    - statcoder.com
  - Statistical coding patterns
    - Expected bell shaped curve

Evaluation and Management Codes
7 Components
The “SCIENCE” of Coding

- Key
  - History
  - Examination
  - Medical Decision Making
- Contributory
  - Counseling
  - Coordination of Care
  - Nature of Presenting Problem
- Explicit
  - Time: Only to assist physician in selection
History
“So why are you here?”

- Includes
  - Chief complaint (CC)
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past, Family and/or Social History (PFSH)

History of the Present Illness (HPI)

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

- Brief HPI
  - 1 to 3 elements
- Extended HPI
  - 4 or more elements

Review of Systems (ROS)

- Constitutional
- Eyes
- ENT
- Cardiovascular
- Respiratory
- Gastrointestinal
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Heme/Lymphatic
- Allergic/Immunologic
- Genitourinary
Review of Systems (ROS)

- Earlier ROS does not need to be re-recorded
- May be recorded by ancillary staff or by the patient
- Document physician review

For a Complete ROS, document all positive or pertinent negative responses
“all other systems reviewed and negative”
“ROS otherwise negative”

History

<table>
<thead>
<tr>
<th>Type</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused (212)</td>
<td>Brief (1-3)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Brief (1-3)</td>
<td>Brief (1)</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed (214)</td>
<td>Extended (4+)</td>
<td>Extended (2-9)</td>
<td>Pertinent (1)</td>
</tr>
<tr>
<td>Comprehensive (215)</td>
<td>Extended (4+)</td>
<td>Complete (10+)</td>
<td>Complete (2/3 or 3/3)</td>
</tr>
</tbody>
</table>

Examination

- Problem Focused (212)
  - Limited to affected body area or organ system
  - 1 body area / organ system
- Expanded Problem Focused (213)
  - Affected body area or organ system and other symptomatic or related organ systems
  - 2 – 4 body areas / organ systems
- Detailed (214)
  - Extended exam of affected body area(s) and other symptomatic or related organ systems
  - 5 – 7 body areas / organ systems
- Comprehensive (215)
  - Complete single system specialty exam or
  - Complete multi-system exam
  - 8 organ systems
Medical Decision Making

- Number of possible diagnoses and/or management options
- Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed
- Risk of complications, morbidity and/or mortality, associated with the patient’s presenting problem, diagnostic procedures, and management options

<table>
<thead>
<tr>
<th>Decision Making</th>
<th>Number of Diagnoses</th>
<th>Amount of Data</th>
<th>Risk of Complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight forward</td>
<td>Minimal</td>
<td>Min. or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

* 2 of 3 elements met or exceeded

Medical Decision-Making

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problems</th>
<th>Diagnostic Procedures</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal (2)</td>
<td>2 or more self-limited</td>
<td>Lab test: Venipuncture</td>
<td>Bandages/rest/drug</td>
</tr>
<tr>
<td>Low (3)</td>
<td>1 stable chronic illness Acute uncomplicated illness or injury</td>
<td>Superficial needle bx</td>
<td>OTC drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lab test: Arterial</td>
<td>Minor surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>puncture</td>
<td>OT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Single x-ray</td>
<td>Closed tx of fx</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physiologic tests</td>
<td></td>
</tr>
<tr>
<td>Moderate (4)</td>
<td>1 or more chronic illness with mild exacerbation</td>
<td>Multiple x-rays</td>
<td>Minor surgery with risks</td>
</tr>
<tr>
<td></td>
<td>1 or more stable acute illness with systemic symptoms</td>
<td>Deep-needle bx</td>
<td>Prescription drugs</td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury Undiagnosed new problem; with uncertain prognosis</td>
<td>LP, joint aspiration</td>
<td>Closed tx of fx</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CT, MRI</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardioimaging</td>
<td></td>
</tr>
<tr>
<td>High (5)</td>
<td>1 or more chronic illness with severe exacerbation</td>
<td>Angiography</td>
<td>Elective major surgery with risks</td>
</tr>
<tr>
<td></td>
<td>2 or more stable chronic illness Abrupt change in neurologic status</td>
<td>Myelography</td>
<td>ER major surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Arthrogram</td>
<td>Parenteral controlled</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>substance/drug therapy w/ Intensive monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DNR</td>
</tr>
</tbody>
</table>
Time

• An explicit factor to assist in selecting the most appropriate level of E/M services
• When counseling and/or coordination of care are more than 50% of the face-to-face encounter, then time is the key controlling factor
• Utilize prolonged services codes (time based)
  *Documentation in the medical record is a must

New Patient

• New Patient
  – No face-to-face services received from the physician or covering physician within the past three years
  – Some codes do not distinguish between new or established patients
    • e.g. emergency or observation codes

Key Concepts – Outpatient E/M Coding

• Time spent is “face-to-face”
• One E/M code per day
  – Few exceptions
    • -25 modifier
    • Prolonged services codes
• Attending physician must see the patient and fulfill / document criteria supporting code used
• Procedures and other services should be coded separately
  – May require modifiers (-25 on the E/M code)
### Office Visits – New Patient

<table>
<thead>
<tr>
<th>Codes</th>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
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<tbody>
<tr>
<td>History</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Exam</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
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<td>Comprehensive</td>
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<td>Decision Making</td>
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<td>Straight forward</td>
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<td>Moderate complex</td>
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<td>20</td>
<td>30</td>
<td>45</td>
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### Office Visits – Established Patient

<table>
<thead>
<tr>
<th>Codes</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
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<tbody>
<tr>
<td>History</td>
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<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Exam</td>
<td>Not Required</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Decision Making</td>
<td>Not Required</td>
<td>Straight forward</td>
<td>Low complex</td>
<td>Moderate complex</td>
<td>High complex</td>
</tr>
<tr>
<td>Time FF</td>
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<td>2 of 3</td>
<td>2 of 3</td>
<td>2 of 3</td>
</tr>
</tbody>
</table>

### The ART of Coding

- The “FEEL” – Established Patient
  - 99211 - Nurse Visit
  - 99212 - Easy, Brief Problems
  - 99213 - Average, Usual Problems
  - 99214 - “OH NO!”
  - 99215 - “Just Ran a Marathon”
99211

- Typical Presenting Problems
  Nurse Visit (Provides an E/M Service)
  - BP check
  - Throat culture
  - Neonate weight check
  - ADHD medication refill
  - PPD check
  - Dressing changes
  - Simple suture removal
  - Immunizations – in addition to administration code
- Document!
- 99211 Typically Triggers a Copay

99212

- Typical Presenting Problems
  - Diaper rash
  - Otitis media recheck – resolved
  - Otitis externa
  - Thrush
  - Minor sports injury

99213

- Typical Presenting Problems
  - Fever and pharyngitis
  - UTI – cystitis
  - URI and otitis
  - Influenza - uncomplicated
99214

- Typical Presenting Problems
  - Chronic problems
  - Headaches
  - Abdominal pain
  - Fatigue, anorexia
  - Fever without focus
  - School, behavioral problems
  - ADD – return visits

99215

- Typical Presenting Problems
  - Diabetes complicated by influenza
  - Chronic headaches with vomiting
  - Abdominal pain, disabling
  - Prolonged fatigue, anorexia in teen
  - Prolonged fever without focus
  - School, behavior problems
  - ADD - initial evaluation

<table>
<thead>
<tr>
<th>Codes</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
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</thead>
<tbody>
<tr>
<td>History</td>
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<td>Problem Focused</td>
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<td>Detailed</td>
<td>Comprehensive</td>
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<tr>
<td></td>
<td>HPI 1-3</td>
<td>ROS N/A</td>
<td>PFSH N/A</td>
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<table>
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<tbody>
<tr>
<td></td>
<td>1 Area</td>
<td>2-4 Areas</td>
<td>5-7 Areas</td>
<td>&gt;8 Areas</td>
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</table>

<table>
<thead>
<tr>
<th>Decision Making</th>
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<th>Low Complex</th>
<th>Mod Complex</th>
<th>High Complex</th>
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<tbody>
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<td>40</td>
</tr>
<tr>
<td>Key #</td>
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<td>2 of 3</td>
<td>2 of 3</td>
<td>2 of 3</td>
<td>2 of 3</td>
</tr>
</tbody>
</table>
99213 → 99214

- CSHCN
- New diagnosis
- Repeat visit – patient worse
- Lab or x-ray ordered
- Consultation indicated
- Prescription written
- Office procedures required (aerosol, pulse ox)
- Chronic problem – exacerbation, changes in Rx
- Time based problem / “consultation”

9921X?

- CC: fever
- HPI: 4 yo est pt fever for 2 days, chills, responding to Tylenol; vomited once. ROS otherwise negative
  Past Hx of strep; no others ill at home
- PE: Skin clear, head normocephalic, throat mod erythema with exudate, neck supple, cervical adenopathy, abd soft, ext nl, neuro nl
- Dx: Pharyngitis, strep FA positive
- Rx: Pen VK, Tylenol, Rest

Medical Necessity
Select E/M Based on Patient’s Complexity

- Determine Medical Decision Making Complexity first
- Then perform and document sufficient history and exam to meet the requirements
- Prevents undervaluing the service
9921X ?

CC: “He has a cold”
HPI: Congestion, cough, and fussiness for 3 days; no fever; eating well but sleeping poorly
PE: Alert, no acute distress; nose congested; throat clear, TM’s erythematous thickened; chest clear; abdomen soft
Impression: Otitis Media
Rx: Watchful waiting vs. amoxicillin, OTC decongestants, Tylenol prn; Recheck prn

9921X ?

CC: Fever and vomiting
HPI: Congestion and wet cough for four days; temp to 103 for two days, vomiting X2 today; irritable with poor feeding, sleeping
PFxs: Hx otitis x 3 in past 6 mos; Fhx: others ill resp illness; SHx: parents smoke
PE: Temp 102.5, RR 24; Wt 22lbs
Fussy but responsive; skin flushed, turgor good; TM’s erythematous, buldging; pharynx mod erythema; neck supple; chest clear to auscultation; heart reg rhythm without murmur; abdomen soft, without masses, tenderness; neuro irritable but responsive
Impression: Otitis Media, recurrent; Vomiting; Fever
Rx: Amoxicillin, Tylenol, Clear fluids with diet advanced as tolerated; discussed in detail including parents concerns with recurrent ear infections
F/U: Return if worse or not improving; Ear recheck in 2 to 3 weeks

Preventive Medicine Services

E/M services performed in the absence of a significant problem/abnormality
Extent and focus depends on the patient’s age
Include counseling/anticipatory guidance/risk factor reduction
Do not include office procedures, ancillary services, and immunizations
Preventive Medicine Services

New Patient
Initial E/M of a new patient including an age and gender appropriate history, examination
Identification of risk factors, ordering of appropriate tests, and counseling

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>RVU / 2009 Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
<td>Age &lt; 1 year</td>
<td>2.51 / $90.53</td>
</tr>
<tr>
<td>99382</td>
<td>Ages 1 – 4 years</td>
<td>2.73 / $98.46</td>
</tr>
<tr>
<td>99383</td>
<td>Ages 5 – 11 years</td>
<td>2.71 / $97.74</td>
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<tr>
<td>99384</td>
<td>Ages 12 – 17 years</td>
<td>2.95 / $106.40</td>
</tr>
<tr>
<td>99385</td>
<td>Ages 18 – 39 years</td>
<td>2.95 / $106.40</td>
</tr>
</tbody>
</table>

Preventive Medicine Services

Established Patient
Periodic reevaluation and management requiring an age and gender appropriate history, examination
Identification of risk factors, ordering of studies, and counseling

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>RVU / 2009 Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>99391</td>
<td>Age &lt; 1</td>
<td>2.09 / $75.38</td>
</tr>
<tr>
<td>99392</td>
<td>Ages 1 – 4 years</td>
<td>2.33 / $84.04</td>
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<tr>
<td>99393</td>
<td>Ages 5 – 11 years</td>
<td>2.32 / $83.67</td>
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<tr>
<td>99394</td>
<td>Ages 12 – 17 years</td>
<td>2.55 / $91.97</td>
</tr>
<tr>
<td>99395</td>
<td>Ages 18 – 39 years</td>
<td>2.56 / $92.33</td>
</tr>
</tbody>
</table>

Preventive Medicine vs. E/M Office Visit?

What do you do if a significant illness or problem is found at a preventive medicine visit?
25 Modifier

- If a significant problem/abnormality is found at a preventive medicine visit:
  - Code the appropriate E/M visit in addition to 99381 – 99395
  - Add modifier -25 to the E/M code
  - If not significant code only 99381 – 99395
  - Option: Have patient return for a separate E/M visit for problem/abnormality found

25 Issues

- Coverage
- NCCI Edits
- Copays
- Separate documentation
- Supporting diagnosis

Preventive Medicine vs. E/M Office Visit?

What if a family’s insurance does not cover preventive medicine and they request the visit billed as an illness encounter?
Office procedures

- Immunizations
- Minor procedures
- Lab and x-ray services
- Medical services
- Screening procedures
- Special services

Objectives
Coding for Vaccines and Toxoids

- To assure appropriate payment for services
- To meet reporting requirements
  - Immunization Registries
  - Vaccine Distribution Programs
- To code for Evaluation and Management Services in addition to immunization codes
- To understand CPT and ICD immunization coding

Vaccines – Mission Critical!

- THE KEY preventive mission for primary care physicians
  - Evidence based
  - Maintains the public health
- Explosion in vaccine products
  - Child born in 2007 will receive over 40 vaccinations prior to adulthood
- Office vaccine delivery system requires clinical and business skills
Best Vaccine Business Practices

- Code correctly
- Contract with knowledge
- Purchase at the best price

Immunizations

- Bill and Document ALL:
  - E/M Visit
    - Office Visit, Preventive Medicine
  - Immunization Administration
    - 90471 - 90474
    - 90465 - 90468 (2005 Peds specific)
  - Vaccine/Toxoid
    - 90476 - 90749
- Link to ICD Diagnoses
  - V20.2 Well Child
  - CSHCN Diagnosis
  - + Specific Vaccine V Codes

EXISTING CPT CODES 2004

Vaccine Administration

- **90471** Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections; one vaccine (single or combination vaccine/toxoid)

- **90472** Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

- **90473** Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)

- **90474** Each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
### 2005 “NEW” CPT CODES

#### Vaccine Administration

- **90465** Immunization administration under 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day
- **90466** Each additional injection (single or combination vaccine/toxoid), per day
- **90467** Immunization administration under age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day
- **90468** Each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)

### Vaccine Administration

#### RVUs for 2009

**Values - Existing codes**

<table>
<thead>
<tr>
<th>Code</th>
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<th>RVU / 2009 Medicare</th>
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<tbody>
<tr>
<td>90471</td>
<td>0.58 / $20.92</td>
<td>90472 - 0.29 / $10.46</td>
</tr>
<tr>
<td>90473</td>
<td>0.38 / $13.71</td>
<td>90474 - 0.25 / $9.02</td>
</tr>
</tbody>
</table>

**Values - New codes**

- **90465** - 0.58 / $20.92
- **90466** - 0.29 / $10.46
- **90467** - 0.38 / $13.71
- **90468** - 0.28 / $10.10

### New Vaccine Counseling Payment Issues

- Payment for extensive additional counseling time related to increased parent concerns
- Payment for time spent counseling when vaccines refused
- Payment for additional counseling when parents insist vaccines spaced out beyond recommended schedule
Time Based Extensive Counseling

- Code based on Time for Office Visit Codes
  Over 50% face-to-face visit time spent counseling
  - 99212 - 10 minutes
  - 99213 - 15 minutes
  - 99214 - 25 minutes
- If provided with preventive medicine visit, add OV E/M code with a -25 modifier

ICD Changes for 2006

- V64.00 Vaccination not carried out
  - V64.01 Acute illness
  - V64.02 Chronic illness
  - V64.03 Immune compromised state
  - V64.04 Allergy to vaccine
  - V64.05 Caregiver refusal
  - V64.06 Patient refusal
  - V64.07 Religious reasons
  - V64.08 Had disease being vaccinated against

Multiple Component Vaccine Issues

- Pros
  - Fewer injections for children
  - Less nurse work/practice expense
  - Documented improved compliance with AAP recommended vaccine schedules (5%)
- Cons
  - Parent concerns with multiple antigen vaccines
  - Loss in immunization administration payments
**Multiple Antigen Vaccine Solutions**

- New Immunization Administration Codes
  - Current AAP COCN initiative
  - Based on number of antigens in vaccines
- Increased payer payment for multiple antigen vaccines
  - Potential win/win
  - Humana: Additional $14 for multiple antigen vaccines
  - United: Additional product payment for Pentacel (List price plus 20% + $10)
  - Positive Medicaid (VFC) precedents in other states

**CPT 2010**

**Effective January 1, 2010**

**Vaccines/Toxoids**

- Term "preservative free" includes products containing either very little or no preservatives
- 90669 revised
  - Pneumococcal vaccine – 7 valent
- ~907XX
  - Pneumococcal vaccine – 13 valent
- 90378
  - Respiratory Syncytial Virus – monoclonal antibody, recombinant, 50 mg each

**Non Face-to-Face Physician Services**

- Telephone calls
- Reviewing records/reports
- Completing forms
- Managing, modifying care plans
- Case management
CPT 2008

- New codes/revisions case management services
- Medical team conference codes
- Behavior change intervention
- Telephone services
- Online medical evaluation
- Category II codes

Telephone Services 2008
“New and Improved”

- Times included in code descriptors allowing correct selection of level
- Codes have been “valued” – CMS
  Final rule for Medicare fee schedule 2008
- Reporting rules exclude double payment for telephone care and E/M care

Telephone Services
CPT 2008

- 99441  Physician to est patient, parent or guardian
  2009 Medicare
  5 – 10 minutes of medical discussion  ($12.62)
  No related E/M service within previous 7 days
  No related E/M service in next 24 hours or next available appointment

- 99442  11 – 20 minutes  ($24.89)
- 99443  21 – 30 minutes  ($38.33)
Non Face-to-Face, Non Physician Services
CPT 2008

- Telephone – by qualified non-physician health care professional
- No related E/M service previous 7 days
- No related other service in next 24 hours or next available appointment

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>98966</td>
<td>5 – 10 minutes medical discussion</td>
<td>$12.26</td>
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<tr>
<td>98967</td>
<td>11 – 20 minutes</td>
<td>$24.89</td>
</tr>
<tr>
<td>98968</td>
<td>21 – 30 minutes</td>
<td>$37.15</td>
</tr>
</tbody>
</table>

Online Medical Evaluation
CPT 2008

- 99444 Online E/M service provided by a physician to an est patient, parent, guardian, or health care provider; Not originating from related E/M service in previous 7 days; In response to patient's online inquiry; Using internet or similar communications network; Requires “timely response”; Permanent storage of encounter ($0.00)

Non Face-to-Face, Non Physician Services
CPT 2008

- Online medical evaluation
- 98969 Online assessment and management by non-physician health care professional; No related assessment and management service in previous 7 days; Using internet or similar electronic communication network; In response to patient's on line inquiry; Timely response with permanent storage of encounter ($0.00)
CSHCN
Children with Special Health Care Needs

Case Management Services
Process in which a physician is responsible for direct care of a patient, and for coordinating and supervising other health care services required.

Case Management Services (new/revised)
CPT 2008

• Medical team conference (99366 – 99368) added
  – 99366 Direct Contact with patient and/or family, 30 minutes or more, non-physician participation, physician participation use E/M face-to-face services
  – 99367 W/O Direct Contact (patient and/or family not present), 30 minutes or more, physician participation
  – 99368 non-physician participation
• 99361 – 99362 DELETED

Behavior Change Intervention

Screening Brief Interventions (SBI)
• Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up
• Examples: Tobacco and Drug/Alcohol SBI
### Behavior Change Intervention

**CPT 2008**

- **99406** Smoking and tobacco use cessation counseling visit, 3 – 10 minutes ($12.98)
- **99407** > 10 minutes ($24.89)
- **99408** Alcohol and/or substance abuse structured screening, and brief intervention, 15 – 30 minutes ($33.18)
- **99409** > 30 minutes ($65.28)

### Behavior Change Intervention

**CPT 2008**

- Provided by: Physician or "other qualified health care professional"

- E/M Service provided same day must be distinct -25 modifier

### Care Plan Oversight

- Only one physician reporting for services provided within a 30 day period
- For supervision of care provided by home health agencies, hospice, and nursing facilities
- Requiring regular physician development / revision of complete multidisciplinary care modalities
- Review of tests and care plans
Care Plan Oversight

- Patient under care of a Home Health Agency
  - 99374 15 – 29 minutes, within a calendar month
  - 99375 30 minutes or more

- Hospice Patient
  - 99377 15 – 29 minutes, within a calendar month
  - 99378 30 minutes or more

- Nursing Facility Patient
  - 99379 15 – 29 minutes, within a calendar month
  - 99380 30 minutes or more

Care Plan Oversight 2006

- 99339: 15 – 29 minutes, within a calendar month
- 99340: 30 minutes or more

Care Plan Oversight patients homes, domiciliaries, or rest homes not under the care of a home health agency, hospice program, or nursing facility

Provide Consultations!

99241-99245

- Payment is 25-42% higher than corresponding new patient office visit codes, and…
- Documentation requirements for History, Exam, and MDM are the same!
- Consult codes are problem-based and can be used for new or established patients
Consultations – 5 R’s
2008

REASON: Medically necessary

REQUEST: By another physician or other appropriate source

RENDER: May initiate diagnostic and/or therapeutic services

REPORT: By written report back to the requesting source

RETURN: Patient back to requesting physician/source

Keyword = “Request”
Referral

Office Consultation / New or Est

<table>
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<tr>
<th>Code</th>
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<th>99243</th>
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</tbody>
</table>
### Inpatient Consult / New or Est.

<table>
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<tr>
<td>Exam</td>
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<td>Comprehensive</td>
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<td>Decision Making</td>
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</table>

### CPT 2010

**Effective January 1, 2010**

**Concurrent Care and Transfer of Care**

- **Concurrent Care**
  - Similar services to same patient by more than one physician on same day
- **Transfer of Care**
  - Physician providing management relinquishes responsibility to another accepting physician
  - Consultation codes only if decision to accept transfer of care cannot be made until initial consultation visit

### CPT 2010

**Effective January 1, 2010**

**Consultations**

- Consultation request documented in patient’s record by either consulting or requesting physician or other appropriate source
- Consultation initiated by patient/family – report office visit or hospital E/M codes, not consultation codes
CPT 2010
Effective January 1, 2010
Consultations

- F/U visits with consultant
  - Established patient E/M codes
  - Additional request for same or new problem from another physician/source, use consultation codes again
  - Services constituting transfer of care use appropriate new/established E/M codes
- Do not report both outpatient and inpatient consultations related to the same inpatient stay

Key Concepts - Inpatient E/M Coding

- Code for services only the day the patient is seen (face-to-face)
- One E/M code per day (few exceptions -25 modifier)
- Time spent is “unit/floor time”
- Attending physician must see the patient and fulfill and document criteria supporting code used
- Procedures should be coded separately (few exceptions – newborn/critical care codes)

Initial Hospital Care / New or Est.

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>History</td>
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<tr>
<td>Exam</td>
<td>Detailed or Comprehensive</td>
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<tr>
<td>Decision Making</td>
<td>Straight or Low Complexity</td>
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<td>3 of 3</td>
<td>3 of 3</td>
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</tbody>
</table>
# The ART of Coding

**• The “FEEL” – Established Patient**
- 99221 - Straightforward
- 99222 - Average, Usual Problems
- 99223 - “OH NO!”

## 99221

**• Typical Presenting Problems**
- Hyperbilirubinemia
- Gastroenteritis/Dehydration
- Cellulitis

## 99222

**• Typical Presenting Problems**
- Pneumonia
- Status Asthmaticus
- Influenza - complicated
99223

• Typical Presenting Problems
  – Encephalopathy
  – Severe Asthma
  – Child Abuse
  – Fever without Focus
  – Failure to Thrive

Subsequent Hospital Care

<table>
<thead>
<tr>
<th>Code</th>
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<tr>
<td>Time/ Floor</td>
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<td>2 of 3</td>
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</tr>
</tbody>
</table>

Hospital Discharge

• 99238
  – Discharge day management of 30 minutes or less

• 99239
  – Discharge day management of more than 30 minutes
**Observation or Inpatient Care**
Same Day Admit/Discharge

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Exam</th>
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<th>Severity</th>
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</tbody>
</table>

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**Normal Newborn Care**
Neonatal/Pediatric Intensive/Critical Care Codes

RENUMBERED!

RELOCATED!

Effective January 1, 2009

---

**Normal Newborn Care**
2009

- 99431 Initial Hospital  →  99460
- 99432 Other Setting  →  99461
- 99433 Subsequent Hospital  →  99462
- 99435 Same day Admit/Discharge  →  99463
- 99238 Discharge ≤30 minutes  →  Unchanged
- 99239 Discharge >30 minutes  →  Unchanged
- 99436 Attendance at delivery  →  99464
- 99440 Delivery Resuscitation  →  99465
Relative Values
Same Day Admit/Discharge

2009 Medicare

• NB Admit 99431 $56.26
  NB Discharge 99238 $66.36
  SD A/D 99435 $75.38

• Admit 99222 $116.93
  Discharge 99238 $64.75
  SD A/D 99235 $161.11

Newborn/Intensive Care Renumbered
After January 1, 2009

• 99431 - 99440 Newborn Care/NB
  Resuscitation report with 99460 – 99465
• 99298 – 99300 Subsequent Intensive Care
  Recovering neonate report with 99478 – 80
• 99289 – 99290 Ped Critical Care
  Pt transport report with 99466 – 99467
• 99295 – 99294 Inpt Neonatal/Ped Critical Care
  Report with 99468 - 99472

Initial Neonatal Care
CPT 2008

• 99477 Initial hospital care, per day,
  neonate (28 days or less), requiring:
  – Intensive observation
  – Frequent interventions
  – Other intensive care services
### Sick Newborn Care / Initial

- 99436 - Attendance at delivery → **99464**
- 99440 - Newborn resuscitation → **99465**
  - Procedures done in Delivery Room
- 99295 - Initial day newborn critical care → **99468**
- 99477 - Initial day newborn intensive care
- 99221-99223 - Initial care of sick newborn
  - If not critical or intensive care
  - All procedures coded separately
- 99358-99359 - Prolonged E/M services, before/after face-to-face
- 99356-99357 - Prolonged E/M services, face-to-face

### Continuing Intensive Care

**2009**

- 99298 – Subsequent Int Care → recovering, <1500gms
- 99299 – Subsequent Int Care → recovering, 1500 – 2500 gms
- 99300 – Subsequent Int Care → recovering, 2501 – 5000gms
- 99478
- 99479
- 99480

### Pediatric Critical Care Pt Transport

**2009**

- 99289 – Critical Care Transport → ≤24 months age
  - 30-74 minutes hands on care
- 99290 – Each additional 30 min
- 99466
- 99467
Inpatient Neonatal Critical Care
2009

- 99295 – Initial day critical care → ≤ 28 days of age
- 99296 – Subsequent critical care → per day
- 99468

Inpatient Pediatric Critical Care
2009

- 99293 – Initial day critical care → 29 days through 24 mos
- 99294 – Subs day critical care → per day, 29 days – 24 mos
- 99475 – Initial day critical care 2 – 5 years
- 99476 – Subs day critical care 2 – 5 years
- 99471
- 99472
- New code 2009
- New code 2009

Critical Care Services
Direct delivery by a physician of medical care for a critically ill or critically injured patient

99291: first hour (30 – 75 minutes)
99292: each additional 30 minutes (> 75 minutes)
If < 30 minutes – appropriate E/M codes

Global codes including most procedures (CPT codes specified)
List separately in addition to code for primary service
Use at any age for critical care in the outpatient setting or for transferred critical care in the inpatient setting
Coding in Addition to Critical Care

- Bill same day E/M codes in addition to hourly critical care (99291 – 99292) when appropriate
  - Emergency Department (99285)
  - Hospital (99233)
  - Consultation: Office (99245)
  - Inpatient (99255)
  - Office (99215)
- Bill procedures not included in hourly critical care
  - Attach –59 modifier
  - Subtract time for non-included procedures from critical care time

Critical Care Services

- "critically ill or critically injured patient"
- "there is imminent or life threatening deterioration of the patient’s condition"
- "involves high complexity decision making… to treat vital system functions… to treat vital organ system failure and/or prevent further life threatening deterioration of the patient’s condition"

Critical Care

- “Critical care and other E/M services may be provided to the same patient on the same date by the same physician”
- “time spent on the floor or unit with family members… may be reported as critical care… provided that conversation bears directly on the management of the patient”
- “time spent performing separately reportable procedures or services should not be included in the time reported as critical care time”
Neonatal Coding Trainers
(Section on Perinatal Pediatrics)

Definition of Critical Care

“Any newborn who requires extensive observation and physiologic monitoring, often invasive, combined with artificial support for one or more failing organs, whose care is most commonly provided in a hospital intensive care unit, commonly involving more than one physician bedside evaluation per day, and where removal of that care would likely lead to death or serious morbidity within a short time frame.”

Transfers

• How do you code for critical care services for children and neonates prior to transfer to tertiary care facilities?

Options
– Duplicate billing of the critical care codes
– *Hospital care codes (99221 – 99233)
  + ALL procedures
  + Inpatient prolonged services time codes (99356 – 99357)
– Add pediatric critical care patient transport if provided (99289 – 99290)
– Hourly critical care for any critical care services provided (including procedures) (99291 – 99292)
Prolonged Services (99354 - 99359)

- Code series defining prolonged services by:
  - Site of service
  - Direct or without direct patient contact
  - Time
- Reported in addition to other physician service, including E/M services at any level
- Total time for a given date, even if the time is not continuous
- Time must be of 30 minutes or more

Prolonged Services

<table>
<thead>
<tr>
<th>Direct Patient Care</th>
<th>Outpatient</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-Face</td>
<td>99354 first hour &gt; 30 min</td>
<td>99356 first hour &gt; 30 min</td>
</tr>
<tr>
<td>Face to Face</td>
<td>99355 each add 30 min &gt; 75 min</td>
<td>99357 each add 30 min &gt; 75 min</td>
</tr>
<tr>
<td>Before or after Face to Face</td>
<td>99358 first hour &gt; 30 min</td>
<td>99358 first hour &gt; 30 min</td>
</tr>
<tr>
<td>Before or after Face to Face</td>
<td>99359 each add 30 min &gt; 75 min</td>
<td>99359 each add 30 min &gt; 75 min</td>
</tr>
</tbody>
</table>

CPT 2010

Effective January 1, 2010
Prolonged Services w/o Direct Pt Contact

- 99358 – 99359
  - May now be reported on a different date than the primary service
  - Ex: extensive record review before or after visit
  - Related to any level of E/M service, where direct face-to-face care will or has occurred
  - Time cumulative, not continuous
  - Use only once per date
Modifiers
Services altered by specific circumstance
Tells insurer "this visit is different"
- 25 Significant separately identifiable E/M service by the same physician on the same day
- 26 Professional component
- 32 Mandated services
- 51 Multiple procedures
- 52 Reduced services
- 59 Distinct procedural service
- 76 Repeat procedure by same physician

Single E/M Code per day
• Multiple outpatient and/or inpatient E/M codes upcoded to a higher single code
• Ex:
  – Observation to admit
  – Outpatient OV to later admit
  – ER visit to later admit
• Must use site of face-to-face service for upcoded service

PROVIDE MORE PROCEDURES!
CODE FOR PROCEDURES!
Code for Those Procedures!

Provide more services with procedures (non-facility):

RVU/$2009 Medicare

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>RVU</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn treatment/first degree</td>
<td>16000 (00)</td>
<td>1.72</td>
<td>$60.73</td>
</tr>
<tr>
<td>Burn treatment/debridement</td>
<td>16020 (00)</td>
<td>2.02</td>
<td>$70.52</td>
</tr>
<tr>
<td>Chemocautery/granuloma</td>
<td>17250 (00)</td>
<td>1.84</td>
<td>$66.36</td>
</tr>
<tr>
<td>Chemocautery/epistaxis</td>
<td>30901 (00)</td>
<td>2.64</td>
<td>$99.22</td>
</tr>
<tr>
<td>Circumcision/newborn</td>
<td>54150 (10)</td>
<td>6.63</td>
<td>$239.12</td>
</tr>
<tr>
<td>FACILITY</td>
<td></td>
<td>2.81</td>
<td>$101.35</td>
</tr>
<tr>
<td>Dorsal penile nerve block</td>
<td>64450 (00)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INCLUDED IN 54150 IN 2007

Code for Those Procedures!

Provide more services with procedures (non-facility):

RVU/2009 Medicare

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>RVU</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign body removal/ear</td>
<td>69200 (00)</td>
<td>3.02</td>
<td>$108.92</td>
</tr>
<tr>
<td>Foreign body removal/nose</td>
<td>30300 (00)</td>
<td>5.47</td>
<td>$186.55</td>
</tr>
<tr>
<td>FB removal/subcutaneous</td>
<td>10120 (10)</td>
<td>3.33</td>
<td>$120.10</td>
</tr>
<tr>
<td>Incision &amp; Drainage/Simple</td>
<td>10060 (10)</td>
<td>2.72</td>
<td>$98.10</td>
</tr>
<tr>
<td>Wart removal (1-14)</td>
<td>17110 (10)</td>
<td>2.70</td>
<td>$97.38</td>
</tr>
<tr>
<td>Wart removal (15 or &gt;)</td>
<td>17111 (10)</td>
<td>3.20</td>
<td>$115.41</td>
</tr>
<tr>
<td>Wound repair/dermabond</td>
<td>12011 (10)</td>
<td>3.87</td>
<td>$135.84</td>
</tr>
</tbody>
</table>

Orthopedic Procedures

2009 RVU/Medicare

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>RVU</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subluxation of radial head</td>
<td>24640</td>
<td>2.89</td>
<td>$104.23</td>
</tr>
<tr>
<td>Closed Rx radial fx</td>
<td>25500</td>
<td>6.23</td>
<td>$218.75</td>
</tr>
<tr>
<td>Closed Rx distal phalanx fx</td>
<td>26750</td>
<td>4.25</td>
<td>$149.09</td>
</tr>
<tr>
<td>Closed Rx proximal or middle phalanx fx</td>
<td>26720</td>
<td>4.55</td>
<td>$159.24</td>
</tr>
<tr>
<td>Closed Rx toe fx</td>
<td>28510</td>
<td>2.87</td>
<td>$100.44</td>
</tr>
<tr>
<td>Closed Rx great toe fx</td>
<td>28490</td>
<td>3.30</td>
<td>$114.82</td>
</tr>
<tr>
<td>Closed Rx clavicle fx</td>
<td>23500</td>
<td>5.12</td>
<td>$184.66</td>
</tr>
<tr>
<td>Splint forearm</td>
<td>29125</td>
<td>1.63</td>
<td>$56.82</td>
</tr>
</tbody>
</table>
CPT Changes 2007

Circumcision Codes Revised
• 54150  Circumcision, clamp or other device, with regional dorsal penile or ring block
  – Use -52 modifier if w/o block
  – Do not separately report 64450 for nerve block
• 54160  Circumcision, surgical, neonate (<=28 days)
• 54161  (>28 days of age)

CPT Changes 2007

Surfactant Administration
• 94610  Intrapulmonary surfactant administration by a physician through endotracheal tube
  – Use in delivery room or outlying hospital prior to transfer
  – Do not use with pediatric or neonatal critical care codes

Use HCPCS Codes for Supplies
• If not included as standard practice expense for the procedure
  (Practice expense component of RBRVS)
• CPT 99070
  General nonspecific code for supplies
• HCPCS codes are preferable
  Alphanumeric
HCPCS Codes

Used to report supplies
- J1100 - Dexamethasone injection, 1 mg
- J0170 - Epinephrine
- J0696 - Ceftriaxone, per 250 mg
- J7619 - Albuterol for inhalation, 1 unit dose

Office Procedures

- Vaccinations
- Minor procedures
- Lab and x-ray services
- Medical services
- Screening procedures
- Special services

Minor Office Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT</th>
<th>RVU / 2009 Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerosol Rx only (X -76)</td>
<td>94640</td>
<td>0.37 / $13.34</td>
</tr>
<tr>
<td>Allergy injection (#1)</td>
<td>95115</td>
<td>0.29 / $10.46</td>
</tr>
<tr>
<td>#2 or more</td>
<td>95117</td>
<td>0.35 / $12.62</td>
</tr>
<tr>
<td>Cerumen Removal</td>
<td>69210</td>
<td>1.25 / $45.08</td>
</tr>
<tr>
<td>Lumbar Puncture</td>
<td>62270</td>
<td>4.14 / $151.59</td>
</tr>
<tr>
<td>Urine Catheterization</td>
<td>51701</td>
<td>1.71 / $58.93</td>
</tr>
<tr>
<td>Venipuncture &lt;3 yrs</td>
<td>36406</td>
<td>0.45 / $15.63</td>
</tr>
<tr>
<td>Venipuncture &gt;3 yrs</td>
<td>36410</td>
<td>0.50 / $17.30</td>
</tr>
<tr>
<td>Venipuncture / Routine</td>
<td>36415</td>
<td>0.26 / $ 9.17</td>
</tr>
<tr>
<td>Finger / Heelstick</td>
<td>36416</td>
<td>0.15 / $5.25</td>
</tr>
</tbody>
</table>
Screening services

RVU / 2009 Medicare
- 92583 - hearing screen, select picture .91 / $31.30
- 92551 - hearing screen, pure tone .29 / $10.46
- 92552 –hearing screen, pure tone threshold.59 / $21.28
- 99173 - visual acuity screening .07 / $2.52
  – may be reported w/ preventive care codes,
  not if part of an E/M service of the eye

Developmental Testing Codes

Central Nervous System Assessments/Tests
- 96110 Developmental testing, limited
  - Performed by office nurse or other trained non-
    physician personnel
  - Parent/guardian report of behavior
  - RVU: 0.36
  - 2009 Medicare: $12.98
  - Modifier -25 may be attached to associated E/M visit
  - Modifier -59 to multiple, additional tests
  - Interpretation and report
  - Documentation in progress report of E/M visit

96110 Examples
- Ages and Stages Questionnaire (ASQ)
- Brigance Early Preschool
- Developmental Profile II
- Early Language Milestone Scales
- PEDS
- PDQ
- Vanderbilt
- MCHAT

- NOT direct physician observation or
general developmental assessment with
checklist of milestones appropriate for age
## Examples of lab and x-ray services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>RVU</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>81000 - dipstick urinalysis w/ micro</td>
<td>0.13</td>
<td>$4.50</td>
</tr>
<tr>
<td>81002 – dipstick urinalysis w/o micro</td>
<td>0.08</td>
<td>$2.78</td>
</tr>
<tr>
<td>81025 - urine pregnancy test</td>
<td>0.08</td>
<td>$2.78</td>
</tr>
<tr>
<td>85018 – hemoglobin</td>
<td>0.10</td>
<td>$3.45</td>
</tr>
<tr>
<td>87172 - pinworm (cellophane) exam</td>
<td>0.18</td>
<td>$6.26</td>
</tr>
<tr>
<td>87880 - strep antigen test</td>
<td>0.98</td>
<td>$33.64</td>
</tr>
<tr>
<td>88400 - transcutaneous bilirubin, total</td>
<td>0.13</td>
<td>$4.56</td>
</tr>
<tr>
<td>71020 - chest x-ray 2 views</td>
<td>0.88</td>
<td>$30.55</td>
</tr>
<tr>
<td>add -26 modifier if indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TC</td>
<td>0.57</td>
<td>$19.50</td>
</tr>
</tbody>
</table>

## Examples of medical services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>RVU</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>96360 - IV fluids, first hour</td>
<td>1.57</td>
<td>$56.62</td>
</tr>
<tr>
<td>96372 - Injection SQ/IM</td>
<td>0.58</td>
<td>$20.17</td>
</tr>
<tr>
<td>93000 – EKG/ w interpretation</td>
<td>0.58</td>
<td>$20.17</td>
</tr>
<tr>
<td>93010 - EKG/ interpretation only</td>
<td>0.25</td>
<td>$8.92</td>
</tr>
<tr>
<td>94010 - spirometry w/o bronchodilator</td>
<td>0.91</td>
<td>$31.20</td>
</tr>
<tr>
<td>94060 - spirometry pre/post-bronchodilator</td>
<td>1.6</td>
<td>$55.08</td>
</tr>
<tr>
<td>86580 - PPD</td>
<td>0.20</td>
<td>$6.91</td>
</tr>
<tr>
<td>94664 – teaching nebulizer, MDI (-59)</td>
<td>0.41</td>
<td>$14.15</td>
</tr>
<tr>
<td>92567 - tympanometry</td>
<td>0.49</td>
<td>$17.57</td>
</tr>
<tr>
<td>94760 - pulse oximetry</td>
<td>0.08</td>
<td>$2.89</td>
</tr>
</tbody>
</table>

## Other Special Office Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>RVU</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Patient Education</td>
<td>0</td>
<td>000 / 000</td>
</tr>
<tr>
<td>Insurance Forms</td>
<td>0</td>
<td>000 / 000</td>
</tr>
</tbody>
</table>
### Preventive Medicine Ancillary Services

<table>
<thead>
<tr>
<th>Screening</th>
<th>RVU / 2009 Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing testing - Select picture</td>
<td>92583</td>
</tr>
<tr>
<td>Hearing testing – Puretone</td>
<td>92551</td>
</tr>
<tr>
<td>Hearing testing – Puretone(threshold)</td>
<td>92552</td>
</tr>
<tr>
<td>Vision screening</td>
<td>99173</td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>96110</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab</th>
<th>RVU / 2009 Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin</td>
<td>85018</td>
</tr>
<tr>
<td>Urine (dip only)</td>
<td>81002</td>
</tr>
<tr>
<td>Routine Venipuncture</td>
<td>36415</td>
</tr>
<tr>
<td>Finger/Heel Stick</td>
<td>36416</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunizations</th>
<th>RVU / 2009 Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization administration</td>
<td>90471/90465</td>
</tr>
<tr>
<td>90472/90466</td>
<td>.29 / $10.46</td>
</tr>
<tr>
<td>Vaccine/Toxoid product</td>
<td>90476-90479</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>RVU / 2009 Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection/other</td>
<td>96372</td>
</tr>
</tbody>
</table>

### Special Services and Reports

**“Modifier-Like” Codes**

- **99000** – Handling and/or conveyance of a specimen from office to laboratory
- **99050** - Services provided in office other than regularly scheduled hours normally closed
- **99051** - Services provided in office during regularly scheduled evening, weekend, holiday hours
- **99053** - Services provided 10PM to 8AM at 24 hour facility
- **99058** - Office services on an emergency basis

Codes billed in addition to basic service

### Optimizing Reimbursement Through CPT Coding

**Utilize Time**

Time spent in counseling and coordination of care greater than 50% of the visit time

Ex: 99213 (15 min) to 99214 (25 min)

Otitis media requiring extensive counseling
ADHD follow up visit

Document time spent and counseling issues
Comprehensive
Detailed
Expanded
Problem
Focused
Not Required
Exam
Not Required
Problem Focused
Expanded Problem Focused
Detailed
Comprehensive

<table>
<thead>
<tr>
<th>Codes</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Required</td>
<td>Not Required</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Elements</td>
<td>HPI 1-3</td>
<td>ROS N/A</td>
<td>PFSH N/A</td>
<td>HPI 1-3</td>
<td>ROS 1</td>
</tr>
<tr>
<td>Exam</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Required</td>
<td>Not Required</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Elements</td>
<td>1 Area</td>
<td>2-4 Areas</td>
<td>5-7 Areas</td>
<td>1 Area</td>
<td>2-4 Areas</td>
</tr>
<tr>
<td>Decision Making</td>
<td>Not Required</td>
<td>Straight forward</td>
<td>Low Complex</td>
<td>Med Complex</td>
<td>High Complex</td>
</tr>
<tr>
<td>Time FF</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>25</td>
<td>40</td>
</tr>
<tr>
<td>Key #</td>
<td>2 of 3</td>
<td>2 of 3</td>
<td>2 of 3</td>
<td>2 of 3</td>
<td>2 of 3</td>
</tr>
</tbody>
</table>

**Documentation / ICD-9-CM**

- ICD coding should support higher levels of coding *(medical necessity)*
- 99213 to 99214
- Code multiple diagnoses
- Document chronic condition when an acute problem is presented
  - Diabetes mellitus
  - Prematurity and related problems

**Code for Extensive Medical Services**

- Optimize standard office visit services
  - Hx, PE, Complexity
  - Time
- $ OV < Prev Med < Consultation
- Utilize prolonged services codes
  - 99354-99359 For excess time spent beyond E/M code
PROVIDE MORE PROCEDURES!
CODE FOR PROCEDURES!

DOCUMENT!
DOCUMENT!
DOCUMENT!

AAP Your CODING CONNECTION
Coding & Reimbursement Resources

• National AAP Coding Hotline: aapcodinghotline@aap.org or (800)433-9016 ext. 4022; free service to members and their office staff
• Coding publications: Coding for Pediatrics, Pediatric Coding Companion, Quick Reference Guides, ICD-9-CM Flipchart, RBRVS Brochure, AAP News Coding Corner
A Hundred Years From Now

It will not matter what my bank account was,
    the sort of house I lived in,
    or the kind of car I drove…
But the world will be different
Because I was important in the life of a
    CHILD