Level That Visit, Code That Diagnosis, Document Your Service
Is there more????

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New Info!!!!

- On March 31, Congress passed the **Protecting Access to Medicare Act of 2014**, which postpones the 24% Medicare physician payment cut for 12 months until April 1, 2015

- **Unexpectedly included in this legislation is a one-year delay of ICD-10-CM implementation, which means the new transition date is Oct. 1, 2015.**

- It has been estimated that upwards of $6 billion has been invested throughout the health care industry in preparation for the updated diagnosis coding system.

- The American Academy of Pediatrics has been working to prepare members for the changeover. **Pediatric practices are encouraged to take the extra time introduced by the delay to master the new nomenclature prior to implementation.**

- "While some practices and organizations were well-prepared for the change, others were not," said Margie C. Andreae, M.D., FAAP, chair of the AAP Committee on Coding and Nomenclature. **"This delay presents an opportunity for practices to conduct more system, process and payer testing prior to the change."**

Conversion Factor for 2014

- Effective on April 1, 2014 the new conversion factor will be $35.82

- This decision stopped the expected 24% cut in payments until January 2015.

- More and more payors are now using the conversion factor and the RBRVS system to configure the reimbursements

What's New in CPT and ICD-9/10

- Lots of changes BUT only a few for primary care!

- BIG revisions to Complex Chronic Care Coordination and Transitional Care

- One real good one: 69210: Removal impacted cerumen!!

- New quadravalent vaccines

- And of course: ICD-10!!!!!

Evaluation and Management

- Interprofessional Consultation:

  - Interprofessional consultations are services requested by telephone or internet by a physician or other qualified health care professional seeking a consultant's expert opinion without a face to face patient encounter with the consultant.

    - 99446: Interprofessional telephone/Internet assessment and mgmt service provided by a consultant physician including a verbal and written report to the pt's treating/requesting physician/qualified health car professional; 5-10 min of medical consultative discussion and review.

    - 99447:   as above; 11-20 min

    - 99448:   as above; 21-30 min

    - 99449:   as above; 31 or more min.

  - EX: when a local physician has a pt that he/she needs further advice and when circumstances such as distance from the consultant or nature of a problem may make a timely face to face patient encounter with the consultant impractical, these are the codes to use.

    - Pediatrician see's a pt for an orthopedic problem and calls a pediatric orthopod for advice on treating the problem. They discuss the pt history and what was found on the exam by the pediatrician and then the Orthopod gives advice and treatment plan. Total time in conversation: 8 min bill 99466.

    - Have to remember that a consult still requires the request, render the service and a report back to the requesting party.

    - May want to warn the parent/pt that they will have a charge from the consulting physician.

Interprofessional Consultation: Continued

- The consulting physician has to document the following:

  - Request for the consultation

  - Review of all data from the requesting provider (including labs, x-rays, medical records etc) regardless if reviewed prior to phone call or after

  - The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal/internet discussion.

- If more than one telephone/internet contact is required, the entirety of the service and the cumulative discussion and information review time should be reported with a single code.

BUT what does the primary care physician bill????

- Obviously bill the visit at the appropriate level of care

  - Remember it's not ALWAYS a 99213!!!

    - The written or verbal request for the telephone/internet advice by the treating/requesting physician or other qualified health care professional should be documented in the patient's medical record, including the reason for the request, and concludes with a verbal opinion report and written report from the consultant to the treating/requesting provider.

  - The treating/requesting provider may report the prolonged service codes (99354-99355) for the time spent on the interprofessional telephone/internet discussion with the consultant IF the time exceeds 30 minutes beyond the typical time of the appropriate E/M service performed and the patient is present (on-site) and accessible to the treating/requesting provider.

    - If billing 99213-need total time of 45 min

    - If billing 99214-need total time of 55 min

    - If billing 99215-need total time of 70 min.

Chronic Care Coordination: revised

- **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**: first hour of clinical staff time directed by a physician or other qualified health care professional with **1** face to face visit, per calendar month

    - when billing this code do not bill the face to face visit

- + **99489**: each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

Complex Chronic Care Coordination Revised 2014!

- Significant revisions to these codes!

  - Cannot report these codes if the plan of care is not changed in a month (or care plan is changed minimally)

  - Involve clinical staff developing, substantially revising and implementing a care plan under direction of the physician or other qualified health care professional.

    - Revision to a care plan will or could occur when the pt's clinical condition changes significantly

      - Identification of a new problem, new interventions, exacerbation of existing problem, and further education to patient and/or caregiver

  - Pts may be identified by recognizing those with multiple illnesses, mult. Medication use, inability to perform activities of daily living, requirement of caregiver, repeat admissions or ER visits.

  - Pediatric pt's usually receive 3 or more therapeutic interventions (meds, nutritional support, respiratory support); have 2 or more chronic continuous or episodic health conditions expected to last at least 12 months or until death.

- The office must have the capabilities:

  - 24/7 access to care providers

  - Standardized methodology to identify pt's who require chronic complex care coordination services

  - Have an internal care coordination process/function

  - Use a form and format in the medical record that is standardized within the practice

  - Be able to engage and educate pt's and caregivers as well as coordinate care amount all service providers as appropriate for each pt.

Reporting month/year_____   **Date of face-to-face, if any** _____

Patient: _____**DOB**_____**MR#**_____**Type of Residence ***_____

Chronic Condition:_____

Other medica conditions:_____

Other Needs (social, access to care): _____

Physician/QHCP_____**Date initial plan of care developed by physician/QHCP:**_____

Date of plan of care provided to patient/caregiver:_____

Transitional Care Management Revisions

- Now for a NEW or established patient

- May report hospital or observation discharge services and TCM however the discharge service may NOT constitute the required face to face visit.

- Cannot bill if this falls into a post operative period.

- REMEMBER: patient has to have moderate or high complexity decision making!

- After first face to face visit, any further E&M visits can be billed separately.

Transitional Care Management Services (TCM)

- These services are for an established patient whose medical and/or psychosocial problems require moderate or high complexity MDM during transition in care from an inpatient hospital setting to the patient's community setting (home, domiciliary, rest home or assisted living). Starts date of discharge and cont. for 29 days.

99495: TCM 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

  - **$120**

99496: TCM 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

  - **$169**

- Do not report the visit during the service time of these codes

- Includes the same codes as the Chronic Care Coordination Codes

- For further information go to www.medicalhomeinfo.org for tool kit for medical home

Removal of Impacted Cerumen-Revised!

- May be good news for payments!

- **69210: Now states: "Removal impacted cerumen _requiring instrumentation_, unilateral**

    - With this new definition carriers may now recognize the work effort put forth having to use instrumentation.

    - Use modifier 50 if cerumen is removed from both ears

        - 69210

        - 69210-50

- If lavage is used instead of instrumentation ONLY bill the E&M code.

If you haven't already begun training on ICD-10, now is the ideal time to start. For those of you who have been training, don't stop.

Quote from the AMA

Do's and Don'ts for ICD-10

- Don't view the announcement as permission to procrastinate.

  - The additional months provide you the opportunity to fine tune what you already have in place and continue to practice.

- Do Dual-code your charts internally and improve the specificity of physician documentation.

- Do Work with your vendor to test with payers so you don't experience financial hardship after October 2015.

Let's Talk Diagnosis Coding

- Use codes at the highest level of specificity

- Use more than one diagnosis as appropriate

  - Those that are pertinent to the visit for that date

- Remember some V codes are informational only

  - IE: V12.29 to V19.19: personal history of…

  - **These will be Z codes for I-10 (Chapter 21)**

- Some V codes are payable:

  - IE: V70.0 General Medical exam

  - **These will be Z codes for I-10 (Chapter 21)**

- E codes have to be used when there is an injury, poisoning and certain other consequences of external causes.

  - E codes describe how or where something happened.

  - **These will be S and T codes for I-10 (chapter 19)**

About Diagnosis Coding

- Need to understand that diagnosis coding HAS to be more specific

  - Learn the new language such as:

    - Acute suppurative left otitis media without spontaneous rupture of eardrum (382.00) NOT

      - Otitis Media, unspecified (382.9)

      - Using a 5 digit code is more specific than a 4 digit code.

    - Right upper quadrant abdominal pain (789.01) NOT

      - Abd pain, unspecified site (789.00)

      - Both 5 digits but 789.01 more specific

    - asthma with acute exacerbation (493.92) NOT

      - Unspecified asthma (493.90)

      - Again, both are 5 digits but 493.92 explains more about the complexity of the visit.

General Timeline

- **Step 1: Impact Analysis**:

  - Time to complete: 3-6 months

- **Step 2: Contact Vendors**

  - Time to complete: 2-3 months

- **Step 3: Contact payors, Billing Service and Clearinghouse**

  - Time to complete: 2-3 months

- **Step 4: Installation of Vendor Upgrades**

  - Time to complete: 3-6 months

- **Step 5: Internal Testing**

  - Time to complete: 2-3 months

- **Step 6: Update internal processes**

  - Time to complete: 2-3 months

- **Step 7: Conduct Staff Training**

  - Time to complete: 2-3 months

- **Step 8: External Testing with Clearinghouses, Billing Service and Payers**

  - Time to complete: 6-9 months

- **Step 9: Make the switch to ICD-10!**

How to Transition to ICD-10

- Encounters that take place *on or after October 1, 2015* are reported with ICD-10-CM codes

- Encounters that take place *before October 1, 2015* are reported with ICD-9-CM codes

- **You will have to run simultaneous systems of ICD-9 and ICD-10 until all your claims from before October 1, 2015 have cleared**.

- Review EMR's or billing programs to make sure they can support both ICD-9 and 10 concurrently

- Review contracts with health plans to see what additional information they need or what will be changing

- Update forms, documentation and internal processes

- EDUCATE providers and staff!!!

  - Encourage provider to document and use more specific codes

  - Less "unspecified" as some payers may not accept them in the future

Some Interesting Facts about ICD-10

· **Will need to refer to the guidelines at the front of book for special instructions**

· X is used as a placeholder character for future expansion-marked with a check mark.

  – Sometimes X is included in the code

  – Other times if a code must be coded to the 7th digit and is subdivided into a fourth or fifth character the placeholder X must be added to the code even if the code has only 5 digits (See 7th Character below)

      · T74.2XXA (initial encounter)

· 7th Characters (found typically in two chapters: 19: Injuries, poisonings and other and 15: pregnancy

  – Chapter 19 7th digit indicates episode of care; chapter 15 is mostly about the fetus

  – Certain I-10 categories have a 7th character.

  – The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instructs.

  – The 7th character **MUST ALWAYS** be the 7th character in the data field.

  – **If a code that requires a 7th character is NOT 6 characters, a placeholder X must be used to fill in the empty characters**.

  – The following 7th character extensions are to be added to each code for this category

      · A initial encounter

      · D subsequent encounter

      · S : sequela

Important Information

- Divided into 2 main parts-just like I-9

  - Index: an alphabetical list of terms and their corresponding codes

  - Tabular List: a sequential alphanumeric list of codes divided into chapters based on body system or condition.

- **Major Change:**

  - Excludes 1: a type 1 excludes note is a pure excludes note. It means "NOT CODED HERE!"

    - Means two conditions cannot happen at same time

    - Excludes 1 note indicates that the code excluded cannot be used with the code above it.

    - EX: congenital form versus acquired form of the same condition

  - Excludes 2: a type 2 excludes note represents "Not Included Here"

    - Indicates that the condition excluded is not part of the condition represented by the code BUT a pt may have both conditions at the same time.

    - When excludes 2 appears under a code it is acceptable to use both the code and the excluded code together, when appropriate

Let's Talk Otitis Media

- There are **36** otitis media diagnosis codes!

- Common code: 382.3-Otitis media, Chronic, suppurative (purulent)

  - **H66 Acute Suppurative and unspecified otitis media**

    - Incl: with myringitis

  - **H66.00 Acute suppurative otitis media without rupture of eardrum**

    - **H66.001 Acute suppurative otitis media, right**

    - **H66.002 Acute suppurative otitis media, left**

    - **H66.003 Acute suppurative otitis media, bilateral**

    - **H66.004 … recurrent right ear**

    - **H66.005 … recurrent left ear**

    - **H66.006 … recurrent bilateral**

  - **H66.01 Acute suppurative otitis media with spontaneous rupture of eardrum**

    - **H66.011 … right ear**

    - **H66.012 … left ear**

    - **H66.013 … bilateral**

    - **H66.014 … recurrent right ear**

    - **H66.015 … recurrent left ear**

    - **H66.016 … recurrent bilateral**

Signs and Symptoms

- Symptoms and signs involving emotional state

- R45.0 Nervousness

- R45.1 Restlessness and agitation

- R45.2 Unhappiness

- R45.3 Demoralization and apathy

- R45.4 Irritability and anger

- R45.5 Hostility

- R45.6 Violent behavior

- R45.7 State of emotional shock and stress, unspecified

- R45.8 Other symptoms and signs involving emotional state

- R45.81 Low self-esteem

- R45.82 Worries

- R45.83 Excessive crying of child, adolescent

Normal Newborn ICD-10

Z38: Liveborn infants according to place of birth and type of delivery

- Z38.0 Single liveborn infant, born in hospital

- Z38.00 Single liveborn infant, delivered vaginally

- Z38.01 Single liveborn infant, delivered by cesarean

- Z38.1 Single liveborn infant, born outside hospital

- Z38.2 Single liveborn infant, unspecified as to place of birth

- Z38.3 Twin liveborn infant, born in hospital

- Z38.30 Twin liveborn infant, delivered vaginally

- Z38.31 Twin liveborn infant, delivered by cesarean

- Z38.4 Twin liveborn infant, born outside hospital

- Z38.5 Twin liveborn infant, unspecified as to place of birth

- Z38.6 Other multiple liveborn infant, born in hospital

- Z38.61 Triplet liveborn infant, delivered vaginally

- Z38.62 Triplet liveborn infant, delivered by cesarean

- Z38.63 Quadruplet liveborn infant, delivered vaginally

- Z38.64 Quadruplet liveborn infant, delivered by cesarean

- Z38.65 Quintuplet liveborn infant, delivered vaginally

- Z38.65 Quintuplet liveborn infant, delivered vaginally

- Z38.66 Quintuplet liveborn infant, delivered by cesarean

- Z38.68 Other multiple liveborn infant, delivered vaginally

- Z38.69 Other multiple liveborn infant, delivered by cesarean

- Z38.7 Other multiple liveborn infant, born outside hospital

- Z38.8 Other multiple liveborn infant, unspecified as to place of birth

Talk About Specific!!!

- T636.22A: Toxic effect of contact with other jellyfish, intentional self-harm, initial encounter

- V954.2XA: Forced landing of spacecraft injuring occupant, initial encounter

- V973.3XA: Sucked into jet engine, initial encounter

- V807.31A: Occupant of animal-drawn vehicle injured in collision with streetcar, initial encounter.

Resources

- Centers for Disease Control (CDC)

    - http://www.cdc.gov/nchs/icd/icd10cm.htm

    - Best resource!

    - Official guidelines

        - Guidelines, code sets, index, GEMS

        - Access WHO here

            - Click on link to find further 1-10 information and free training

- AMA: http://www.ama-assn.org/go/icd-10

    - Version 5010 conversion toolkit, archived websites, general information, I-10 FAQS and tips

- CMS: https://www.cms.gov/icd10/

    - Current updates/information/news, implementation news, payer resources, vendor resources, statute and regulations

- *from AMA ICD-10 Workshop

How to Code Those Sick Visits

- Remember that not all sick visits are a 99213 or 99214!

- Key factors: history/physical and medical decision making

  - Each level has different criteria

- Time can also be a key factor and the only factor!

- New patient visits require all three key factors, established only two of the three, unless you are using time.

History of Present Illness

- **Timing**: Indication of when something occurs, i.e.: number of occurrences or freq. of s/s. (1 time, constant, intermittent)

- **Quality**: A description of discomfort (sharp, dull, stabbing, acute, chronic, improving)

- **Severity**: A measurement of discomfort, sensation or pain. The extent of process (e.g. grading and staging carcinomas).

- **Context**: A description of where the pt. is and what the patient is doing when the s/s begin. (occurred at, during, while, fell from porch)

- **Location**: Where on the body are the s/s's located

- **Duration**: From what starting point did the s/s's begin (6 months, 3 months, yesterday)

- **Assoc. S/S's**: What other, positive or negative s/s does the pt. have at presentation (nausea with vomiting, head inj: no LOC, pain in right arm and shoulder etc)

- **Modifying Factors**: What has the pt/physician attempted to do to obtain relief/or treat

Breaking down the history's

- Problem Focused: 99201(new pt); 99212 (established pt); 99224 (sub obs care); 99231 (sub hosp care)

    - HPI = 1-3

    - ROS = 0

    - PMFSH = 0

- Expanded Problem Focused: 99202 (new pt); 99213 (est. pt); 99225 (sub obs care); 99232 (sub hosp care);

    - HPI = 1-3

    - ROS = 1 (pertinent)

    - PMFSH = 0

- Detailed: 99203 (new pt); 99214 (est pt);99218 (ini. Obs); 99226 (sub obs care); 99221 (ini adm); 99233 (sub hosp care)

    - HPI = 4+

    - ROS = 2-9 (pertinent)

    - PMFSH = 1 (pertinent)

- Comprehensive: 99204/99205 (new pt); 99215 (est pt); 99222/99223 (ini adm); 99219/99220 (ini Obs)

    - HPI = 4+

    - ROS = 10+ (or some with statement: Remainder of systems negative) (pertinent)

    - PMFSH = 3 for those that require all three key factors/ 2 for all others

Physical 95 Guidelines

- You can use the 97 guidelines but they are speciality specific such as Cardiology, Pulmonology

- Four Types of Physical in 95 guidelines
  - Problem focused: 1 organ system
    - Exam limited to affected body area or organ system
  - Expanded problem focused: 2-7
    - Limited exam of affected body area or system and 1-6 symptomatic or related systems
  - Detailed problem focused: Ext. 2-7
    - Extended exam of affected body area(s) or system(s) and other symptomatic or related organ system(s).
  - Comprehensive problem focused: 8+ or complete.
    - General Multi-system or complete single organ system exam
      - Must be "system(s)", don't count body areas

Risk of Complications

Level of Risk	Presenting Problems	Diagnostic procedures	Management options
Minimal	1 self limited	Lab test-veni punct.	Bandages / rest / drsg
Low	2 or more self limited 1 stable chronic illness Acute uncomp. Illness or inj.	Superficial needle bx Lab test- art punc Single x-ray Physiologic tests	OTC drugs Minor surgery OT
Moderate	1 or more chronic illness with mild exacerbation 2 or more stable Acute illness with systemic sympt. Acute comp. inj. Undiag. New prob. With uncertain prog.	Multiple x-rays Deep needle bx LP, joint asp. CT, MRI Cardio imaging	Minor surgery with risks Elective major surgery Prescription Drugs Closed tx of fx
High	1 or more chronic with severe exacerbation Acute illness with threat to life/limb Abrupt change in neurologic status	Discography Myelography arthrogram	Elective major surgery with risks/ER major surgery Parenteral controlled substance/Drug therapy with intensive monitoring DNR

Two out of three elements must be met or exceeded for a given level of Medical Decision Making			
Risk of complications	Number of DX and/or mgmt options	Amount and / or complexity of data to be reviewed	Level of MDM

Minimal	(PTS / ITEMS)
	1 pt Minimal
	    1 self limited
	    1 est. problem
		1 pt Order and / or review lab
		1 pt Order and / or review radiology
		        test	

Low	2 pts Low
	    2 self limited / minor
	    2 est. problems
	    1 est. worsening
	    1 stable chronic
		1 pt Order and / or review other tests-
		        EKG / PFT
		2 pts Direct visualization and
		        independent review of
		        image/tracing or spec.	

Moderate	3 pts Moderate
	    1 new prob. w/o add. work up
	    3 established problems
	    2 est. problems, one worsening
		1 pt Decision to obtain old records
		        and / or history other than pt
		2 pts. Review & summarize old records
		        and / or obtain hx other than pt	

High	4 pts High
	    1 new problem w/add work up
	    4 established problems
	    2 established prob. worsening
	Total Points_____
		2 pts. Discuss case with
		        other health care
		        provider
		
		Total Points_____	

Minimal	1 pt Minimal	< 1 pt Minimal	Straightforward
Low	2 pts Low	2 pt Low	Low
Moderate	3 pts Moderate	3 pts Moderate	Moderate
High	4 pts High	4 pts High	High

Time as a Key Factor

- Time can be used as the key factor when: counseling constitutes more than 50% of the visit in face to face contact with the patient/parents.

- Physician has to document the amount of time spent in this discussion period and what was discussed.

- Total time spent for New Patient Visit, Established Patient Visit, Consultations:

- **Pick the code that is closest to the time noted**

99201: 10 min	99212: 10 min	99241: 15 min
99202: 20 min	99213: 15 min	99242: 30 min
99203: 30 min	99214: 25 min	99243: 40 min
99204: 45min	99215: 40 min	99244: 60 min
99205: 60 min		99245: 80 min

Last But Not Least: Preventive Care and the "Oh - By The Way" Visit!

- Preventive Care Codes (99381-99397) do not have the same key factors as other Eval/Mgmt codes do

    - Extent and focus of the services will largely depend on the age of the patient

    - Comprehensive nature of the codes reflects an age and gender appropriate history/exam

- If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this service, and it is significant enough to require additional work, code an office visit also.

    - Use a 25 modifier with the office visit

    - Different diagnosis than the Preventive Medicine Services

- **Does not include vision and hearing screening.**

Billing Both HME and Office Visit

- Dictate two separate notes to demonstrate that "two"
  - Services were performed on that date of service.
  - Ex: 1st   note impression: Well Exam
    - 2nd   note Impression: Chronic problem diagnosis
  - Or acute problem diagnosis.
- Don't list issues or sick problems in well note.
  - Ex: Do ROS, PMH and Social History, Current Medicines typically obtained during a well exam (specific to age and gender of pt) but do not do HPI for chief complaint. Not pertinent to health maintenance exam.
- When documenting second note for "sick" visit, include
  - Chief components for the HPI, pertinent ROS and impression and plan.   if a visit is "carved out" of a well exam, the visit is of low complexity. Otherwise, carriers feel you are not performing a well exam to begin with.
- If using time as a key factor:
  - Remember to dictate a Separate note and indicate the length of time spent in counseling and what was discussed during the counseling session (diet, non-compliance to meds etc)
    - The time documented has to show total time for well child visit and total time for the "sick" visit.

Risk Factor Reduction

- If counseling on an issue normally performed during the well care visit, consider using the preventive medicine counseling codes

  - 99401: preventive medicine counseling and/or risk factor reduction intervention provided to an individual; approx. 15 min

  - 99402:   approx. 30 min

  - 99403:   approx. 45 min

  - 99404:   approx. 60 min.

- AAP recommends using these codes when the counseling on a vaccine is more involved than normal instead of the vaccine counseling codes.

  - When documenting those services you will have to state the amount of time spent in counseling and a brief description of the counseling

    - Spent 15 min. discussing the vaccines required at 2 months and Mother states is concerned about autism. Discussed pro's and con's of vaccines, media information etc.   Bill 99401.

- Reimbursement is approximately the same as a 99213 to 99214.

- Great code to use when discussing a patients high BMI and what they need to do to improve.
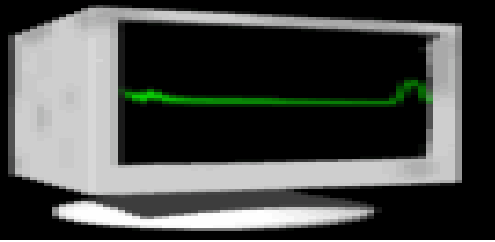
Critical Care

- **99291**: Initial 30-74 minutes of critical care on a given date

  - 99292: each additional 30 minutes beyond the first 74 minutes

- Can be done in the physician's office where age is not a factor

- Critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

- CC is usually provided **but not always** in a critical care area.

- CC can be provided daily

- CC and other E&M services may be provided on the same patient on the same date by the same physician

Newborn Care

- **99460**: Initial hospital/birthing center care, per day, for the E/M of the normal newborn infant

  - Includes maternal and/or fetal and newborn history

  - Newborn physical examination

  - Ordering of diagnostic tests and treatments

  - Meetings with the family

  - Documentation in the medical record

- **99461**: Initial care, per day, for the E/M of the normal newborn infant seen in other than hospital or birthing center

- **99462**: Subsequent hospital care, per day, for evaluation and management of normal newborn

- **99463**: Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date

- ICD-9 code = V30.XX

- ICD-10 code = Z38.0?

Immunization Administration

- Descriptor:

    - 90460: immunization administration through 18 years of age via any route of administration, with counseling by physician or "other qualified health care professional"; first **or only component of each vaccine/or** toxoid component administered

    - 90461:   each additional/OR toxoid component administered

- A component refers to each antigen in a vaccine that prevents disease(s) caused by one organism.

- Conjugates or adjuvants contained in vaccines **ARE NOT** considered to be component parts of the vaccine. Multivalent antigens or multiple serotypes of antigens against a single organism are considered a **SINGLE** component of vaccines.

- Be sure to be specific when documenting your counseling:

    - **"I counseled on MMR, pro's and con's for the vaccine explained, VIS sheet given and explained and questions answered"**

    - Be sure to list all vaccines being counseled on.

- **Continue to use the 25 modifier on a visit (well or sick) when vaccines and admin codes are billed at the same time. This will over ride the NCCI edit.**

Other Vaccine Administration Codes: 90471 - 90474

- Vaccines administration that **does not have face to face physician or qualified health care professional counseling to the patient/family or for administration of vaccines for patient older than 18 years of age use**:

    - 90471: 1st vaccine (IM, SubQ, intradermal)

    - 90472: each additional vaccine (IM, SubQ, intradermal)

    - 90473: 1st vaccine oral/intranasal vaccine

    - 90474: each additional vaccine (oral/intranasal)

- As before if giving initial IM and initial intranasal use the subsequent intranasal vaccine and not the initial

    - 90471 for initial IM vaccine, 90474 for initial intranasal vaccine

    - If bill 90471 and 90473 (both initial) you will get denial for two initial vaccine administration codes on same date of service.

Can you bill for an office visit and a procedure on the same day?
YES YOU CAN

- Bill a visit when the patient presents for problems and a procedure is **"needed"** to help determine a definitive diagnosis

  - Incision and drainage of an abscess

- Do NOT bill for a visit when the patient presents and the procedure has already been determined to be done at this visit at a previous visit.

  - Removal of wart (diagnosed week prior and told to come back for removal)

- You will need to use modifier 25 on the VISIT only.

- Don't forget to use different diagnosis for visit and procedure.

- **REMEMBER: you have to make a separate notation for the procedure**

  - **How procedure was performed**

  - **Results**

  - **How tolerated**

Breathing Procedures

- Always use the highest level of specificity in your diagnosis

- 94640: Pressurized or non-pressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device)

  - Don't forget to use the 76 modifier when giving more than one breathing treatment

- 94664: Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB devise.

  - can be reported only one time per day

  - **Requires 59 modifier if billed same date as nebulizer treatment**

  - Can be claimed when office staff perform demo under supervision

  - Medicare only allows billing of this procedure every 30 days

Minor Procedures

- **20600:** Arthrocentesis: bursa or small joint ($44)

- **20605**: ", intermediate joint ($61)

- **20610**: ", large joint ($56)

- **10060:** I & D abscess, simple ($86)

- **11730:** Avulsion of nail plate, partial or complete, simple, single ($73)

    - **11732**: each additional nail plate

- **11740**: Evacuation of subungual hematoma ($37)

- **17250**: Chemical cauterization of granulation tissue ($78)

- **10120**: FB subq tissue via simple incision ($114.75)

    - Includes removal of splinters when physician has to go beneath the skin to remove splinter

- **28190**: FB-foot ($196.76)

- **30300**: FB-nose ($180.76)

- **11200**: Skin tag removal; up to 15 lesions ($65.75)

- **41010**: Incision in the lingual frenulum to free the tongue ($161)

- Application of splints:

    - Short arm splint (forearm to hand): static-**29125 ($49)** dynamic-**29126 ($58)**

    - Finger splint: static- **29130** ($30.75) dynamic-**29131 ($39.25)**

    - Short leg splint (calf to foot): **29515 ($54.50)**

    - **A4570**: Splint **S8450-S9452**: Splint, prefabricated for finger, wrist, ankle or elbow

- Strapping

    - Shoulder: **29240 ($43)**

    - Elbow or wrist: **29260 ($39)**

- **24640:** nursemaid elbow (10 day post op) ($107.75)

Even More Procedures

- Fracture Care (have 90 day post op period)

  - **23500**: Clavicle fx **($164)**   **25500**: Radial Fx **($204)**
    26750: distal phalangeal fx **($139)**

  - **26720**: Proximal or middle phalanx, finger or thumb fx

  - **28490**: Great Toe Fx **($111)**   **28470**: Metatarsal Fx
    28510: Fx phalanx or phalanges other than
    great toe **($93)**

- **93000**: Electrocardiogram, routine ECG with at least 12 leads, with interpretation and report **($13.50)**

- **93005**:   tracing only, without interp and report **($7.50)**

- **93010**:   interpretation and report only **($6)**

Modifiers used with E&M Codes

- **25: Used to indicate the Eval/Mgmt. service is a separately identifiable service (minor procedure)**

  - Used only on visits to let the carriers know that on that day the provider determined that a minor procedure needed to be performed

- **57: Used to indicate that the Eval/Mgmt. service was done to determine the need for surgery (major procedure)**

  - Used only on visits to let the carriers know that on that day the provider made the decision that a major procedure was needed and it is the preoperative visit.

- **24: Used to indicate that the Eval/Mgmt. service was unrelated to a major procedure**

  - Only use this modifier on visit codes when there has been a major procedure (like a fracture) performed within the 90 days of that service. It indicates that it should be paid and is not part of the postoperative period.

Modifiers for Procedures

- **59: Used to indicate that the procedure is a distinct service**

  - Use this modifier on a procedure that typically tends to get bundled into another service. This modifier will allow the over-ride of a bundling edit.

- **76: Used to indicate that the same procedure was performed on the same day by the same physician on the same patient**

  - This modifier only is used on a procedure to let the carriers know that more than one service of the same kind was performed that day and both (or more) should be paid separately

- **53: Discontinued procedure**

  - Indicates to the carrier that a procedure was started but for some reason had to be discontinued before the procedure was completed.

  - Do not reduce your fee, some carriers will reduce it for you by 25%

- **52: Reduced service**

  - Indicates to the carrier that the procedure was not as complex as listed in CPT

  - Do not reduce your fee, some carriers will reduce it for you by 25%