

# Good Grief Not Coding Again!!

By  
Donelle Holle, R.N.  
[dhollled@pedscoding.com](mailto:dhollled@pedscoding.com)

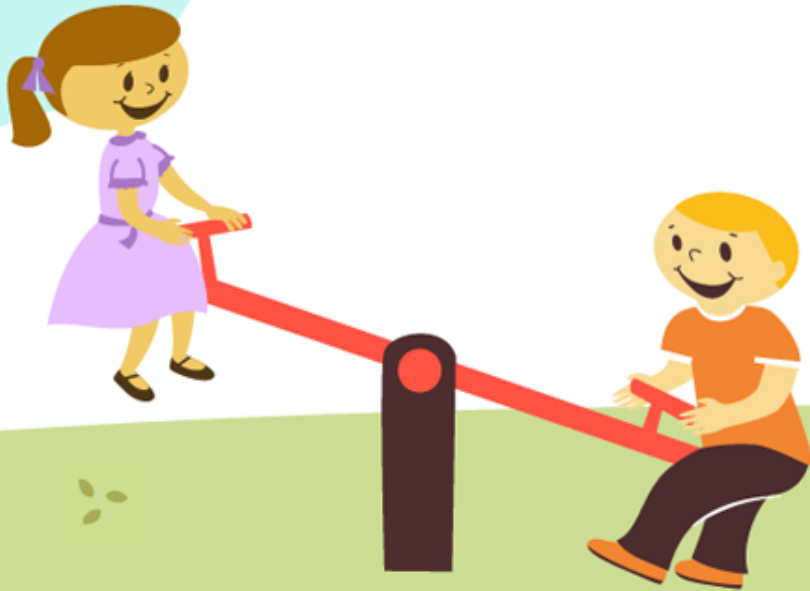


# Notice and Disclaimer

- I have tried to include accurate and comprehensive information in this presentation and it is not intended to be legal advice.
- Every effort was made to ensure that this presentation was current and accurate as of the date of publication. The presentation was prepared as a tool to assist providers and staff and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure accuracy of the information within this presentation, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The information presented should not be construed as legal, tax, or accounting advice.
- I have a financial affiliation with the following:
  - Speakers Bureau: Sanofi Pasteur
  - Speakers Bureau: Audio Educators
  - Speakers Bureau: AAP
  - Editorial Board: The Coding Institute Pediatric Coding Alert
- CPT is a trademark of the American Medical Association and is their copyright



Let's Change It Up  
ICD-10 First!



# Important Facts to Remember

- Always code to the highest degree of specificity
  - Look to be certain that the code you are using doesn't have another code that describes it in deeper detail
    - Z00.12: Encounter for routine child health exam but under that code are two more codes to indicate further specificity.
- Use more than one diagnosis code when applicable
- All chronic diagnoses should be documented as often as they are assessed or treated.
  - Child has Trisomy 21 (Down's syndrome with heart issues) and presents with fever and cough
- Accidents, injuries and poisonings (chapter 19) should have a secondary diagnosis from Chapter 20 as to how it happened
  - These codes will need a 7<sup>th</sup> digit added to the stated diagnosis code
- Z codes ARE payable!
  - Some Z codes may be informational
    - Z07.09 Personal history of other diseases of the respiratory system (asthma)
  - Some are payable
    - Z00.129: Encounter for routine child health exam without abnormal findings



# Some New/Additions/Deletions/changes ICD-10 for 2020 (proposed)

- Chapter 1
- B97.4 RSV as the cause of diseases classified elsewhere
- They have added:
  - Code First: related disorders, such as OM (H65.-)
  - URI (J06.9)
  - Excludes 2: Acute bronchiolitis due to respiratory syncytial virus (RSV) (J21.0)
    - Acute Bronchitis due to Respiratory syncytial virus (RSV) (J20.5)
    - Respiratory syncytial virus (RSV) pneumonia (J21.0)
- This addition is important and will give a further specificity to the RSV DX. Note the first dx listed should be related disorders such as OM or even URI with the secondary being the RSV, IF, you don't have a more specific RSV code.



# Continuing ICD-10 Changes for 2020

- Chapter 4
- E66 Overweight and obesity
- Excludes 1: Revised from Prader-Willi syndrome (Q87.1)  
Revised to: Prader-Willi syndrome (Q87.11) Additional 5<sup>th</sup> digit to this code.
- Chapter 6
- G43.A Cyclical vomiting
- ADD: Excludes 1: cyclical vomiting syndrome unrelated to migraine (R11.15)
  - Revise from: G43.A0 Cyclical vomiting, not intractable  
Revised to: G43.A0 Cyclical vomiting, in migraine, not intractable
- Important to note that these now include in migraine and are differentiated by being intractable versus not intractable.



# More Changes to ICD-10 2020

- Chapter 8
- H65 Nonsuppurative otitis media
- Use additional
- Revise from           code to identify:
- Revise to           code, IF APPLICABLE, to identify: infectious agent (B95-B97)
- Reason important change is that typically the infectious agent for the non-suppurative OM is not known



# Just A Few More

- Chapter 10
- J06.9 Acute upper respiratory infections of multiple and unspecified sites
  - Add Use additional code (B95-B97) to identify infectious agent, if known such as:
  - Add RSV (97.4)
- J12.1 Respiratory syncytial virus pneumonia
  - Add RSV pneumonia removed the word virus
- J20.5 Acute bronchitis due to respiratory syncytial virus
  - Add Acute bronchitis due to RSV basically allowing RSV in place of the entire name.
- J21.0 Acute bronchiolitis due to respiratory syncytial virus
  - Add acute bronchiolitis due to RSV





# And they continue! ICD-10 that Is!

- Chapter 17 Congenital Malformations, deformations and chromosomal abnormalities
  - Take a look at this chapter, there are a number of additions and a few deletions which might be a necessary secondary or tertiary diagnosis especially when seeing that neonate from the NICU.
  - Remember- congenital issues should be listed if they have been discussed during a visit.
- Chapter 18
- R11.1 Vomiting
  - Add R11.15 Cyclical vomiting syndrome unrelated to migraine
  - Add cyclic vomiting syndrome NOS
  - Add persistent vomiting
  - Add Excludes 1: cyclical vomiting in migraine (G43.A-)
  - Add Excludes 2: bulimia nervosa (F50.2)
  - Add diabetes mellitus due to underlying condition (E08.-)



# And Continue!

- Chapter 19 as there are many revisions and additions to skull fractures, facial fractures.
  - These may not be applicable very often but on occasion Pediatrics will see a child who has fallen off of a dirt bike with no helmet, MVA, skate boarding accident etc.
- Keep in mind that some of the changes may not make a lot of sense:
  - V43.13 Revised from: Car passenger injured in a collision with a pick-up in non-traffic accident
  - V43.13 Revised to: Car passenger injured in a collision with a pick-up TRUCK in non-traffic accident-
    - Difference is TRUCK!
- Chapter 20- note some changes and deletions with dirt bike accidents.



# And Continue!!

- Chapter 21- Those Z Codes!
- Z01.02 Encounter for examination of eyes and vision following failed vision screening
  - Add (Z01.01) Excludes 1: Examination for examination of eyes and vision with abnormal findings  
Yes, it is examination for examination!!!!
  - Add (Z01.00) Examination for examination of eyes and vision without abnormal findings
- Add Z01.020 Encounter for examination of eyes and vision following failed vision screening without abnormal findings
- Add Z01.021 Encounter for examination of eyes and vision following failed vision screening with abnormal findings
- Add findings Use Additional code to identify abnormal findings



# At last-the end!

- Z68 Body Mass Index
  - Revised the age grouping from 2 to 20 years to 2 to 19 years
- Z71.8 Other specified counseling
  - Add Z71.84 Encounter for health counseling related to travel
  - Add Encounter for health risk and safety counseling for (international) travel
  - Add Code Also: if applicable, encounter for immunization (Z23)
  - Add Excludes 2: encounter for administrative examination (Z02.-)
  - Add encounter for other special examination without complaint, suspected or reported diagnosis (Z01.-)

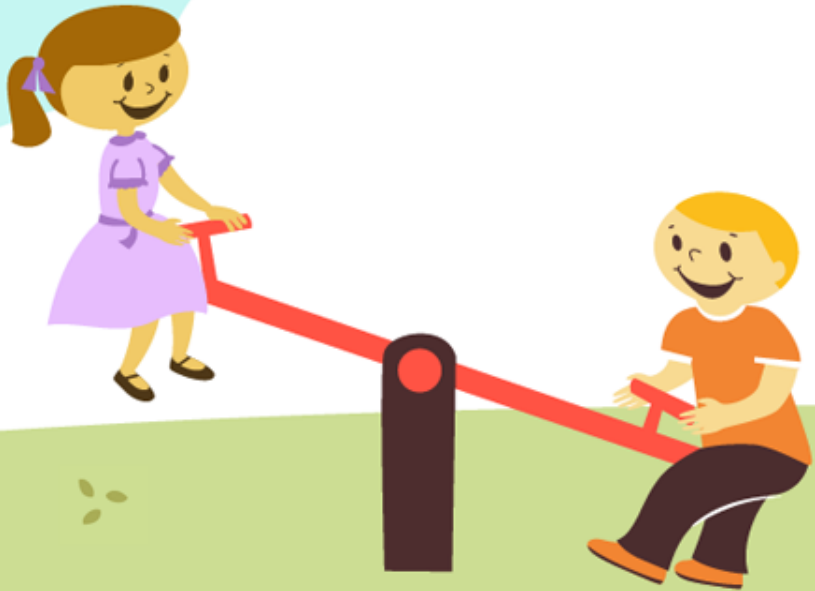


# How About Some “Old” Codes

- R06.03 Acute Respiratory Distress
  - When a child presents in severe respiratory distress use this code to demonstrate the high complexity of the visit
- Z03.89 Encounter for observation of a specified condition, ruled out
  - Use this code when child presents for an illness that is not present
  - Do NOT use feared well or worried well
- Z05.08 Observation and evaluation of a specified condition in a neonate not found
  - Useful payable diagnosis code when seeing that neonate at their 3-5 day old visit if using sick visit codes (99201-99215)
- Z79.899 Long term use of current medication
  - Consider using this diagnosis code if a patient is on medication for a mental health illness
  - Used in lieu of the mental health diagnosis



So What's New With  
CPT Since January?



# CPT ADDITIONS, REVISIONS AND DELETIONS

- 132 New codes
  - Most in the surgical, radiology and pathology and laboratory section.
  - 6 Evaluation and Management Codes
    - 5 revisions
- 49 Revisions
- 21 Deletions
- Very few changes that will affect Pediatrics
- Couple new Interpersonal E & M Codes
- Lots of resequenced codes
  - Resequenced codes means the codes have NOT been deleted but placed between codes that are not sequential
    - 90672: Flu virus vaccine, quadrivalent live (LAIV4) for intranasal use placed between 90660 and 90661



# How Much Will You Get Paid in 2019

- Medicare pays based on relative value units (RVU)
  - An RVU is a number assigned to CPT codes and a conversion factor or amount of revenue paid per RVU.
  - This payment is also affected by geographical index and practice cost indexes
    - These MAY cause the RVU attached to a CPT code to be higher or lower this year
- Conversion factor 2018: \$35.99
- Conversion factor 2019: \$36.05 (increase of .06 cents!)
- Importance of knowing RVU is to know how to determine approximate amount of reimbursement for new codes and established codes
  - Important to be able to work with payers on reimbursement for the next year.
  - Able to “prove” to the payer why a particular code should be paid at a higher amount if you are getting paid lower than what Medicare would pay.





# Negative Impact for Pediatrics!

- Even though the conversion factor went up EVER SO SLIGHTLY
- Primary Care will probably see a 1.5% reduction overall in payments!
  - This means approximately \$3000 to \$10000 decrease per year in take home pay for the providers!
  - (information provided by Chip Hart, Director of Pediatric Solutions with PCC )
- Biggest hit was vaccine administration codes which took an 18.9% reduction!
  - 90460- RVU from .58 to .47 Payments from \$20 to \$16
  - 90471 same situation
  - No reduction in the 90461 or the 90472
  - G codes for vaccine administration will also be reduced as they follow the 90471 payment.
- Another hit were the screening codes for development or emotional/behavioral but improved on the nutritional counseling, tympanometry.
- E&M codes have been increased very slightly
  - Most of the RVU for sick visits went up .02
  - Most of the RVU for well care went up .01



# Payment Changes You Might See

- Granted not **A LOT** of increase in payment but ...
  - 99391: Preventive visit: established patient, infant - \$101.16 to \$101.63 (RVU: 2.81/2.82)
  - 99460: Initial Newborn Care - \$97.56 to \$97.67 (RVU: 2.71/2.71)
- Most will see a decrease! All administration codes took a hit
  - 96372: Therapeutic, prophylactic, or diagnostic Injection, SC, IM - \$20.88 to \$16.94 (RVU .58/.47)- down 18.9%
  - 90471: Vaccine administration, initial IM, Subq, Intradermal - \$20.88 to \$16.94 (RVU .58/.47)
  - G codes will more than likely take the same hit.
- Go to CMS Physician Look Up Tool for all CPT code payments to help determine if your charge is correct and up to date.
- Remember not ALL payers go by the RBRVU system to determine their payments
- Some new codes may not be payable by other payers just because they are payable by Medicare.



# Changes They Are Coming!

- Extremely Brief Overview: (PCC session on Friday at 9:45 much more detail!!)
  - Coming in 2021
  - Deletion of CPT code 99201
    - I told you that you would never do that code!
  - Significant changes to determining level of care most likely based strictly based on Medical Decision Making OR the TOTAL TIME spent on the day of the encounter
    - Hopefully will make determining this piece of the pie much less subjective and making it standard to that an auditor no matter where they are from will come to the same conclusion.
    - Using the total time of the visit instead of only being able to use it when it is >50% of the total amount of time in counseling as well as changing the amount of time associated with each level of care taking consideration of the time in obtaining a history.



# Interprofessional New Codes

- 99451: Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
  - Does not include a verbal component
  - Approximately \$26 payment by Medicare.
  - Cannot bill if patient seen within the past 14 days or when the consultation results in a face to face visit within the next 14 days.
- 99452: Interprofessional telephone/Internet/Electronic Health Record referral service(s) provided by a treating/requesting physician or QHP, 30 minutes (\$26)
  - Primary pediatrician has a new patient present with multiple chronic issues and is referring the patient to a multiple consultants-calls the some of the consultants, discusses the patient being referred to them-spends time getting information that needs to be sent to each one of them as well.
  - Need 16 to 30 minutes
  - Can only be reported once in a 14-day period
  - If time is exceeded, may use the prolonged care service codes (non-face to face 99358/9 if non face to face). Must exceed by 30 minutes.



# NEW REMOTE MONITORING

- 99453: remote monitoring of physiologic parameters: set up and patient education on use of equipment (weight, blood pressure, pulse oximetry, flow rate), during a 30 day period
  - Cannot be reported if less than 16 days of monitoring
- 99454: device(s) supply with daily recording(S) or programmed alert(s) transmission, each 30 days
  - Has to be a device approved by the FDA
- 99457: Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other QHP time in a calendar month requiring interactive communication with the patient/caregiver during the month.



# More New Codes for Primary Care

- 99491: Chronic care management services, provided personally by a physician or other QHP, at least 30 minutes of physician or other QHP time, per calendar month, with the following elements
  - Multiple(two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - Comprehensive care plan established, implemented, revised, or monitored.
    - Plan MUST be shared with the patient and/or caregiver
  - Physician (practice) is available 24/7 to patient/caregiver
    - Typical pediatric patients will have neurological issues, syndromes etc.
  - CMS requires that the family is notified of CCM services and parents agree.
- New Vaccine: still FDA pending (lightning bolt) so cannot be used as of this date
  - 90689: influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25ml, dosage, for intramuscular use



# Development, Central Nervous System and Behavior Identification Assessment

- 96112: Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social memory and/or executive functions by standardized developmental instruments when performed), by physician or QHP, with interpretation and report; first hour
  - 96113 each additional 30 minutes.
  - Will typically be used by the developmental pediatrician.
- 96130-96137: New Psychological and Neuropsychological testing
  - Greater than 2 tests administered.
  - Psychological testing and evaluation services by a physician or QHP
  - 96130, 96132, 96136 are first hour
  - 96131, 96133, 96137 each additional hour
- 97151-97157: Behavior Identification assessment and adaptive behavior treatment.
  - Review all of these new codes if this is your type of specialty as these codes will not be used to administer typical behavior or developmental screening or treatments performed by General Pediatrics.



And they continue!

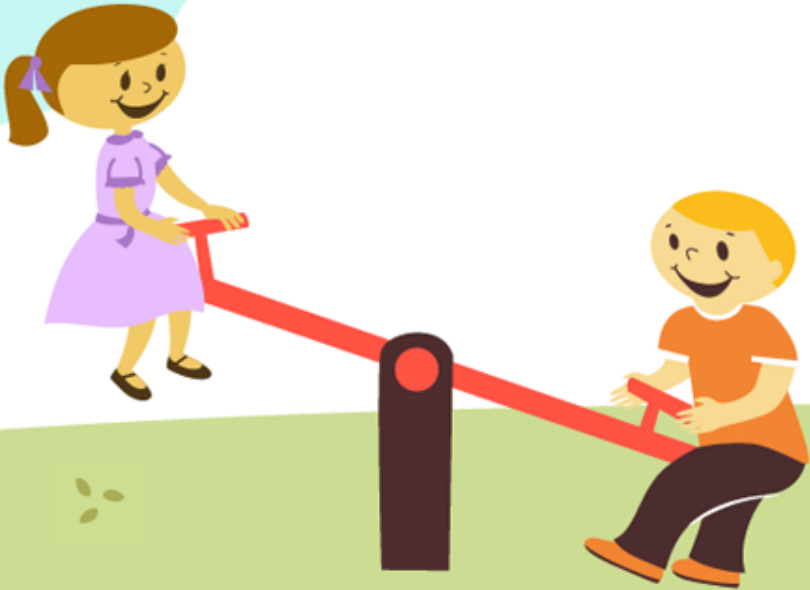
- 43763: Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance, not requiring revision of gastrostomy tract.





# Let's Talk My Favorite Subject- VISITS!!!!

No, You Can't Leave Now!! This is my favorite part!!



# Let's Start with Well Care!

## You Know How I love to talk about Well Care!

- Remember:
  - The extent and focus of the services will largely depend on the age of the patient
  - The “comprehensive” nature of the WCC reflects an age and gender appropriate history/exam and is NOT synonymous with the “comprehensive” history/exam required in the E&M codes 99201-99233
  - Included is counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination.
- **99381-99387**: New patient preventive medicine codes
- **99391-99397**: Established patient preventive medicine codes
  - These codes are age specific (infant-< 1 year; early childhood-age 1 to 4 yrs.; late childhood-age 5 to 11 yrs.; adolescent-age 12 to 17 yrs.; 18 to 39 yrs.; 40-64 yrs. and 65 years and older)



# What Is In Well Care

- Well care should be done yearly to provide best medical care in regards to development, nutrition and immunizations.
  - These yearly visits tend to drop off between ages 7-12
  - Remind parents of importance of tracking them between these ages any time they present in the office.
- All Chronic issues have to be addressed in well care
  - If there is a chronic problem that is not stable, the use of an additional sick visit code is appropriate to address those issues and treatment plan.
- History is pertinent to Age and Gender
  - Includes review of system, PM, F and S History
    - Requires a comprehensive history BUT that is not synonymous with a comprehensive history as in a sick visit
  - Comprehensive physical is required
    - Have to include percentages for growth
      - IE: Weight (BMI), Height and Head (infant)



# Well Care (Continued)

- Anticipatory Guidance
  - Also age and gender specific
    - Development, safety, nutrition counseling, exercise counseling, Stranger Danger, TV-video viewing, Drugs, Sex, Alcohol
- Immunizations
  - Counseling on vaccines must be documented
    - Risks and benefits discussed, VIS sheet given and discussed, caregiver questions were answered on all vaccines given today. Consent for vaccines was also given today.
    - Must document if parents refuse vaccine      Add Z28.82
- If issue is discovered during well care, may constitute an additional sick visit code
  - BMI: if patient presents with BMI that is increasing and your nutrition counseling (performed at all well care visits) goes beyond the “normal”, bill an additional sick visit code using time as a key factor
- **Does not include vision , hearing, developmental or Health Risk Assessment screening. These are billed separately!**
  - When billing Multiple screenings like Vanderbilts, bill when screening comes back for interpretation and review, not when given to parents.



## 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
- 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 and also on the well care services if other ancillary well care was performed
  - Different diagnosis than the Preventive Medicine Services
  - Have to have a separate note documented
    - Do not repeat the physical
    - Record the history (HPI, ROS, PMFS) and Medical Decision Making pertinent to the chief complaint and presenting problems.
    - Use the Z code Z00.121 (well care with abnormal findings)

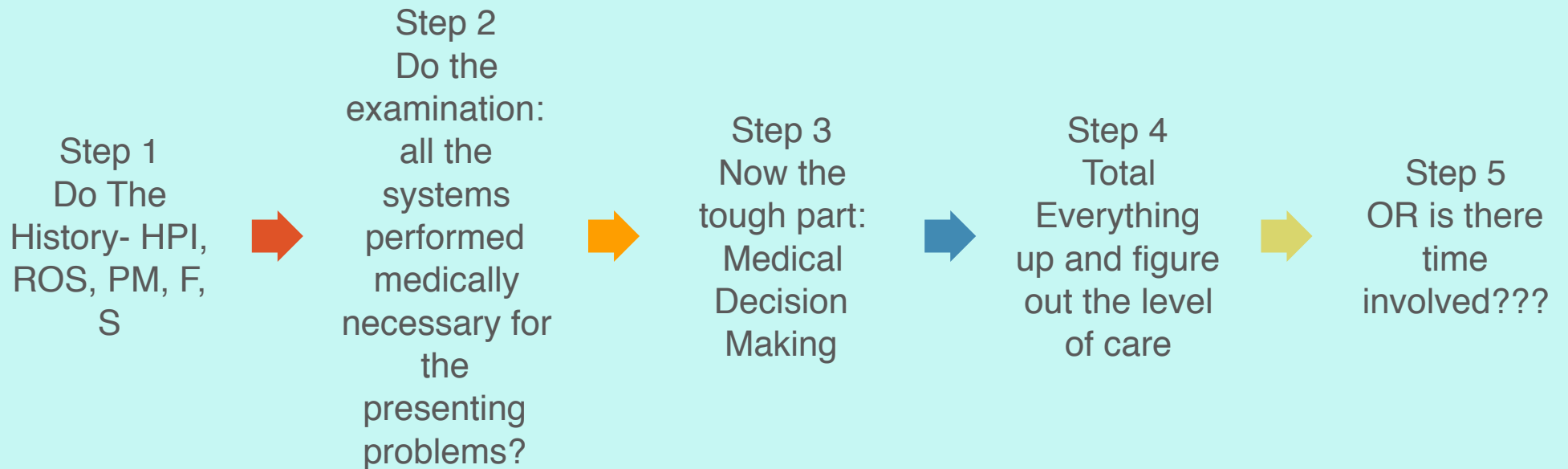


# Know the Difference Between New and Established

- Most common error in documentation and coding is in the new patient sick office visits -99201-99205.
  - 5 levels of care for a new patient sick visit
  - 4 levels of care for an established patient sick visit
  - This means that the levels tend to “go down” with a new patient visit
    - Example: a 99203 is thought to be the same as a 99213, HOWEVER, it is more like a 99214!!
  - Providers HAVE to know the criteria for each level of new patient visit as well as established sick visits!
  - A new patient is one who has had NO PROVIDER SERVICE in a 3 year span
    - If came in for flu shot but only saw a nurse, even every year, but no face to face with a provider, the patient becomes NEW after 3 years from last face to face with a provider service!!!!



# How Do You Figure Out That Level Of Care?



# Oh That History! Let's Talk Sick Visits

- ALWAYS tell who the historian is-don't just state who brought them into the office
- 4 types of history:
  - Problem focused: 1-3 HPI (history of present illness)
  - Expanded Problem focused: 1-3 HPI, 1 ROS (review of systems)
  - Detailed: (most common hx obtained in Pediatrics): 4+HPI, 2-9 ROS, **1 PERTINENT PM (past medical), F (family) or S (social)**
  - Comprehensive: 4+ HPI, 10+ ROS, 3 of 3 for new PM, F, S or 2 of 3 for established.
- They type of history obtained should be medically necessary to treat the patient for the chief complaint and presenting problems.
  - IE: infant (under 12 months of age) presents with a fever for >2 days as high as 102/teen with severe headache so bad that can't stand any light in her eyes/4 year old with vague complaints but been ill for over a week and losing weight may all require a comprehensive history!!!
  - IE: A 6 year old presenting with fever 102 with sore throat, a 10 year old with known asthma with an exacerbation, a 2 year old with runny nose and cough probably will NOT require a comprehensive history or comprehensive exam





# History of Present Illness

- Duration: when did it start
- Assoc. S&S: what else is going on
- Modifying factor: have you tried anything to help
- Timing: how many times has it happened, times do you get it, how often taken
- Severity: how bad is the problem-pain: 1-10, is patient crying in pain
- Location: where is the pain or problem
- Context: how did it happen
- Quality: better, worse, acute, chronic, description of CC



# Physical Examination

- Physical Examination
  - 97 guidelines are more for subspecialty practices and you have to count bullet items.
    - Specialties like General, Cardiovascular, Eye, ENT, GU, Respiratory, Hem/Lymph/Immunologic, Skin, MS, Neurological and Psychological
  - 95 counts systems OR body areas, not both!
    - Constitutional, Eyes, ENT, Respiratory, Cardia, GI, GU, Neuro, Musculoskeletal, Hem/lymph, Skin, Psych
  - Number of systems in exam determined by history and what is medically necessary to treat patient for presenting problems.
  - Difference between an expanded problem focused exam and detailed exam:
    - EPF = 2 to 7 brief systems
    - Detailed = 1 system in detail with 1-6 other brief systems
      - Respiratory system would require respiratory rate, assessment of respiratory effort, auscultation as well as re-evaluations as needed



# Examination: 95 Guidelines

- For purposes of examination, the following organ systems are recognized:
  - Constitutional (e.g., vital signs, general appearance)
  - Eyes
  - Ears, nose, mouth and throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Skin
  - Neurologic
  - Psychiatric
  - Hematologic/lymphatic/immunologic

- For purposes of examination, the following body areas are recognized:
  - Head, including the face
  - Neck
  - Chest, including breasts and axillae
  - Abdomen
  - Genitalia, groin, buttocks
  - Back, including spine
  - Each extremity



# Medical Decision Making Low, Moderate, High???

- Hardest part of determining the level of care-this factor will be revised in 2021!
  - Revising the “number of diagnoses or management options” to Number and Complexity of Problems Addressed”
  - Revising “amount and/or complexity of Data to be reviewed” to “Amount and/or Complexity of Data to be Reviewed and Analyzed”
  - Revising “Risk of Complications and/or Morbidity or Mortality” to “risk of Complications and/or Morbidity or Mortality of Patient Management”
- SO- In the meantime-learn how it is done now:
  - 2 of 3 that match determine the MDM
    - Risk
    - DX
    - Data



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(16)

99213: 15 min(13)

99242: 30 min

99203: 30 min(26)

99214: 25 min(21)

99243: 40 min

99204: 45min(38)

99215: 40 min(33)

99244: 60 min

99205: 60 min(53)

99245: 80 min



# Prolonged Care Non Face to Face

- 99358: 30-74 minutes of prolonged care, non-face to face .
- 99359: each additional 30 minutes of prolonged care, non-face to face
  - Can be pre or post visit.
  - Time is used to review other information on the patient, talking with other specialists involved in the patient care, documenting notes in the patient chart for further reference.
  - Total time has to be documented
  - Billed under patient's name and ID
  - Requires at a minimum of 31 minutes.
  - Now reimbursed by Medicare!!
    - 99358: \$121.00
    - 99359: \$66.00





# Just a Reminder!

- **99291/2: Critical Care Codes**
  - Patient has to be critically ill with a life threatening illness/injury or organ system failure
  - Have to have a minimum of 30 minutes (30 to 74 min) for 99291 (99292 is each additional 30 min.)
  - Includes everything performed during the visit
  - Does not include history, physical and MDM
  - Document reason for visit, patient is critically ill, findings, treatment plan and total time in visit (does not count time doing procedures)



# Procedures Anyone?



# Of Course You Can Do A Visit and Procedure- As Long As You Check Off All The Boxes!

- There has to be a reason to do a visit when a procedure is performed on the same date
  - It is extremely rare in Pediatrics NOT to have a visit on the same date-typically the visit is used to determine the need for the procedure to treat the patient for the presenting problems.
  - IE: Patient presents with injury to the elbow when she was yanked off the monkey bars at school
    - After obtaining a history and brief examination, it was determined that she had a subluxation of the radial head so a procedure is performed to return the ligament to its original position so that the radial bone can move back into its normal place. (nursemaid elbow).
    - Both the visit with a 25 modifier is used as well as the procedure 24640
  - IF you have already determined the need for a procedure and the patient returns to have the procedure done on a different date-you will NOT do another visit at that date.



# BUT Some Services Are NOT Procedures!

- Many “procedure” like activity may occur during a visit but are considered an integral part of the visit
  - Administering a medication like Tylenol
  - Nasal Aspiration
  - Fluorescein strip for possible corneal abrasion with slit lamp
  - Steristrip of a laceration
  - Insertion of ear wick (or removal)
  - Removal of ear wax that is not impacted



# Supplies and Drugs

- 99070: (supplies and materials, except spectacles, provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided))
- Use HCPCS codes instead of 99070
  - A codes are supplies such as mask and tubing's, catheters
    - A7003: Administration kit for small vol. nebulizer
  - J codes are medications
    - J0696: Injection, ceftriaxone sodium, per 250 mg (Rocephin)



# Minor Procedures

- 20600: Arthrocentesis: bursa or small joint (\$44)
- 20605: “, intermediate joint (\$61)
- 20610: “, large joint (\$56)
- 11730: Avulsion of nail plate, partial or complete, simple, single (\$73)
  - 11732: each additional nail plate
- 11740: Evacuation of subungual hematoma (\$37)
- 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) dx Q38.1
- 69209: Removal impacted cerumen, without instrumentation, unilateral (\$12.92)
- 69210: Removal impacted cerumen, with instrumentation, unilateral (\$49.89)



# Other Minor Procedures

- 10060: Incision and Drainage, Simple
  - Used when there is a cellulitis/abscess that needs to be drained.
  - 10 post op days (\$121.68)
- 17250: Chemical Cauterization of Granulation Tissue
  - 14 day old infant presents for a sick visit because Mom is stating the baby is bleeding from the abdomen! On evaluation the physician notices there is a granuloma on the umbilicus, using a silver nitrate stick they cauterize the umbilical granuloma
    - ICD-10: P83.81: umbilical granuloma
  - 0 post op days
  - \$82.44 payment from Medicare



# Removal of Impacted Cerumen

## Not just one, but two

- 69209: Removal impacted cerumen using irrigation/lavage, unilateral
  - Use modifier 50 if bilateral
  - Remember that the wax has to be impacted.
  - \$14.40
- 69210: Removal impacted cerumen requiring instrumentation, unilateral
  - \$49.68
  - Use modifier 50 if cerumen is removed from both ears
    - 69210
    - 69210-50
- Both still have to be documented
- Cannot report both together
  - IE: Attempted to remove impacted cerumen per lavage and then instrumentation was used-bill only the 69210.
- ICD-10
  - H61.21-3 for right, left and bilateral





# Even More Procedures

- 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)
- 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 (\$93)



# Screenings

- 96110: Developmental Screening (eg: developmental milestone survey, speech and language delay screen), per standardized instrument
- 96127: Brief emotional and behavioral assessment (eg: depression inventory, attention-deficit disorder/hyperactivity (ADHD scale) with scoring and documentation, per standardized form
- 96160: patient focused
  - Administration of patient-focused health risk assessment instrument (eg. Health hazard appraisal-SCAT, SCAT 2 and SCAT 3 for children under 12) with scoring and documentation, per standardized instrument) (\$4.67)
- 96161: caregiver-focused
  - Administration of caregiver-focused health risk assessment instrument (eg: depression inventory-Edinburgh) for the benefit of the patient, with scoring and documentation, per standardized instrument. (\$4.67)



Instrument	Abbreviation	CPT code
Ages and Stages Questionnaire - Third Edition	ASQ	96110
Ages and Stages Questionnaire: Social-Emotional	ASQ:SE	96127
Australian Scale for Asperger's Syndrome	ASAS	96127
Beck Youth Inventories - Second Edition	BYI-II	96127
Behavior Assessment Scale for Children – 2nd Edition	BASC-2	96127
Behavioral Rating Inventory of Executive Function	BRIEF	96127
Briggance Screens II	(No Abbreviation)	96127
Brief Infant and Toddler Social Emotional Assessment	BITSEA	96127
Connor's Rating Scale	(No Abbreviation)	96127
Denver II	(No Abbreviation)	96110
Kutcher Adolescent Depression Scale	(No Abbreviation)	96127
Modified Checklist for Autism in Toddlers	M-CHAT	96110
Patient Health Questionnaire	PHQ-2 or PHQ-9	96127
Parents' Evaluation of Developmental Status	PEDS	96110
Pediatric Symptom Checklist	PSC	96127
Pediatric Symptom Checklist - Youth Report	Y-PSC	96127
Screen for Child Anxiety Related Disorders	SCARED	96127
Strength and Difficulties Questionnaire	SDQ	96127
Substance Abuse and Alcohol Abuse Screening	CRAFFT	96160
Vanderbilt Rating	(No Abbreviation)	96127
Concussion screening: Sport Concussion Assessment tool	SCAT	96160
Edinburgh (maternal depression)	(No Abbreviation)	96161

# Vaccine Administration Coding

- 90460: Administration and counseling on a vaccine, initial component ages 0 through 18 yrs., any route
- 90461: “, each additional component
  - Requires documentation on counseling “Risks and benefits counseled on vaccines, VIS sheet explained and questions answered and consent for vaccines given”
- 90471: Administration of initial vaccine; IM, Subq, Intradermal
  - Use when there is no counseling by a provider or patient is 19 yrs. old and up to
- 90472: each additional vaccine; IM, Subq, Intradermal
- 90473: Administration of initial vaccine; oral or intranasal
- 90474: each additional oral/intranasal vaccine



# Do You Do Audits In Your Practice?

- You should!
- More and more carriers are now doing some auditing
  - Most have no particular reason, just random (supposedly!)
- Pulling notes at random (higher level of care, new patient visits-most common that will have errors in documentation)
- Do this every month, just a couple per provider or if you have an outlier (someone billing all 99214-99215 or someone billing all 99212-99213) look at theirs more often
- If you do get an audit, print the notes for the carrier, do not let them use our computer to look at the notes
  - If you do have them come on-site, and you use the computer-always sit with them and work the computer.
- **DON'T** be afraid to argue on your side as to the level you claimed! They expect you will not argue and you just pay back the amount they state was overpaid.

