

Essential Coding Basics 2016: Turning Knowledge to Payment!

Joel Bradley, MD, FAAP

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American Academy of Pediatrics

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Faculty Disclosure Information

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I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.



- Based on this presentation, changes you may wish to make in practice:
 - Better understand the four KEY areas of Coding and Payment
 - Improve your business acumen by making coding directly support payments AND new value based \$ incentive programs
 - Learn how you can now afford to implement new care model with high requirement for population health- care coordination and care management

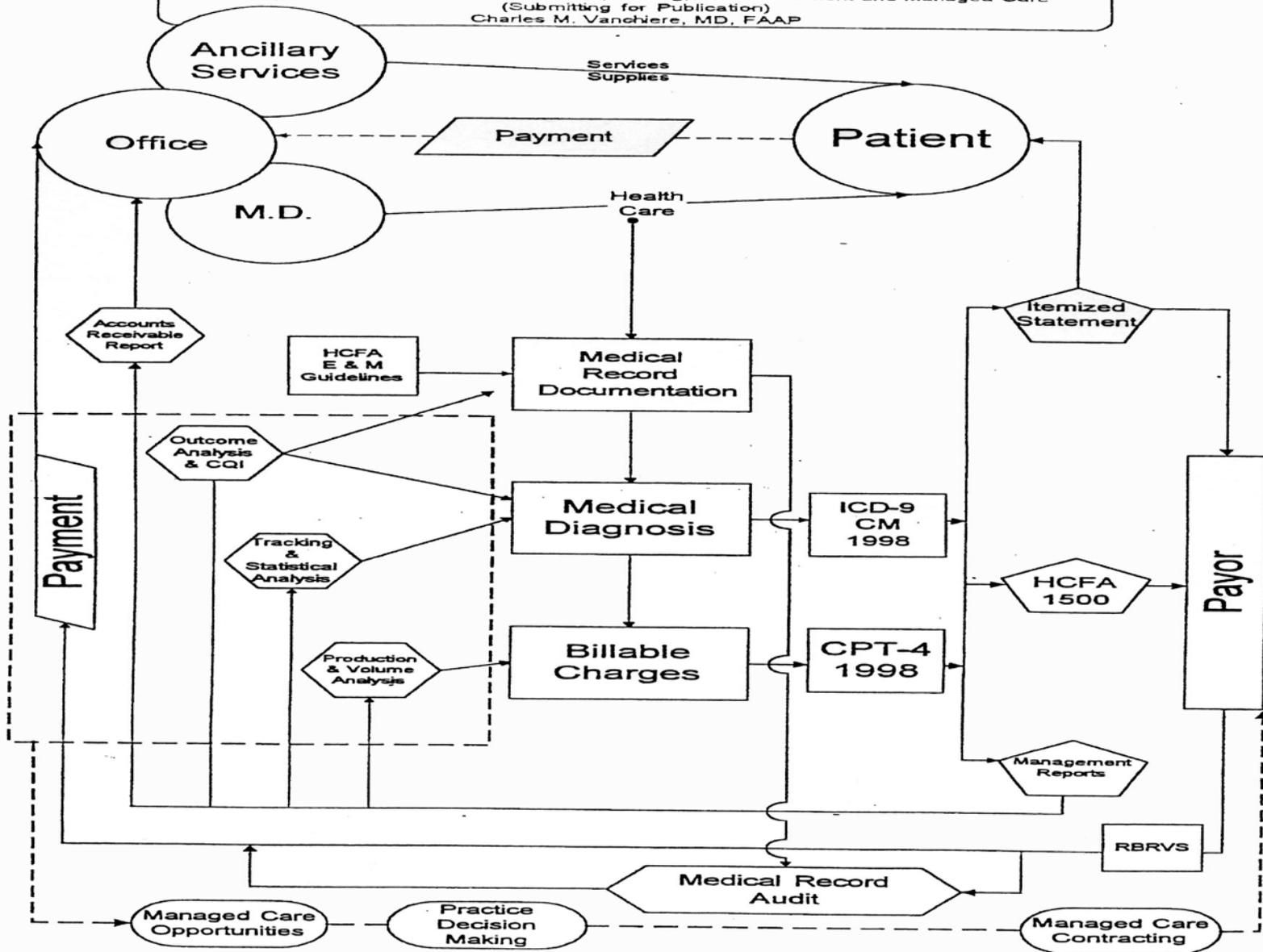


- Four Key Areas of coding Knowledge
 - EM Codes- New and Old
 - Procedure and Vaccines
 - ICD 10- New Codes
 - Modifiers



Medical Encounter

"The Medical Encounter—Documentation, Coding, Reimbursement and Managed Care"
 (Submitting for Publication)
 Charles M. Vanchiere, MD, FAAP



THE REVENUE CYCLE (GETTING PAID)

- Provide the services
- Find the correct billing codes
- Assign your fee to each service billed
- Report (Bill) the claim
- Receive your EOB (explanation of benefit) with payment
- Deposit your payment or a denial with a reason ,
(AND NEW)
Participate in Pay for Value programs



WHY CODE CORRECTLY? THE LIST GROWS!!

- That how you get paid for clinical activity (service-code-claim-\$)
- *There is a rapidly evolving alternative payment landscape- Value Based Payment- often additive to your fee schedule (P4P)*
- “Narrow” or Tiered Payer Networks will have “higher value” providers
- There is compliance risk if you don’t- fraud, waste, abuse



VALUE BASED CODING

- Bundled Payments- are composed of costs defined by CPT and ICD codes
- Quality metrics- most defined by ICD and CPT codes billed (“administrative measures”)
- Risk adjustment for cost of your patient is based largely on ICD coding (medical complexity – “my patients are sicker”)
- Population health- stratification defined by risk analytics- coding , utilization, EBM
- Care Gaps- defined by claims and EBM rules- example- a vaccine delay is found comparing claims with EBM (CDC ACIP recommendations)



CREATING VALUE IN YOUR PRACTICE

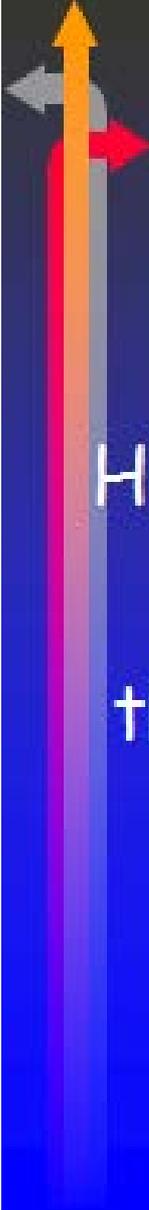
- The Triple Aim - Improving –
 - health care (delivery- eg PCMH)
 - quality of care (outcomes- eg NCQA Measures)
 - the cost of care (right care at right time and right place)
- Creating Value Value = Quality / Cost
- **Payment will follow Value**



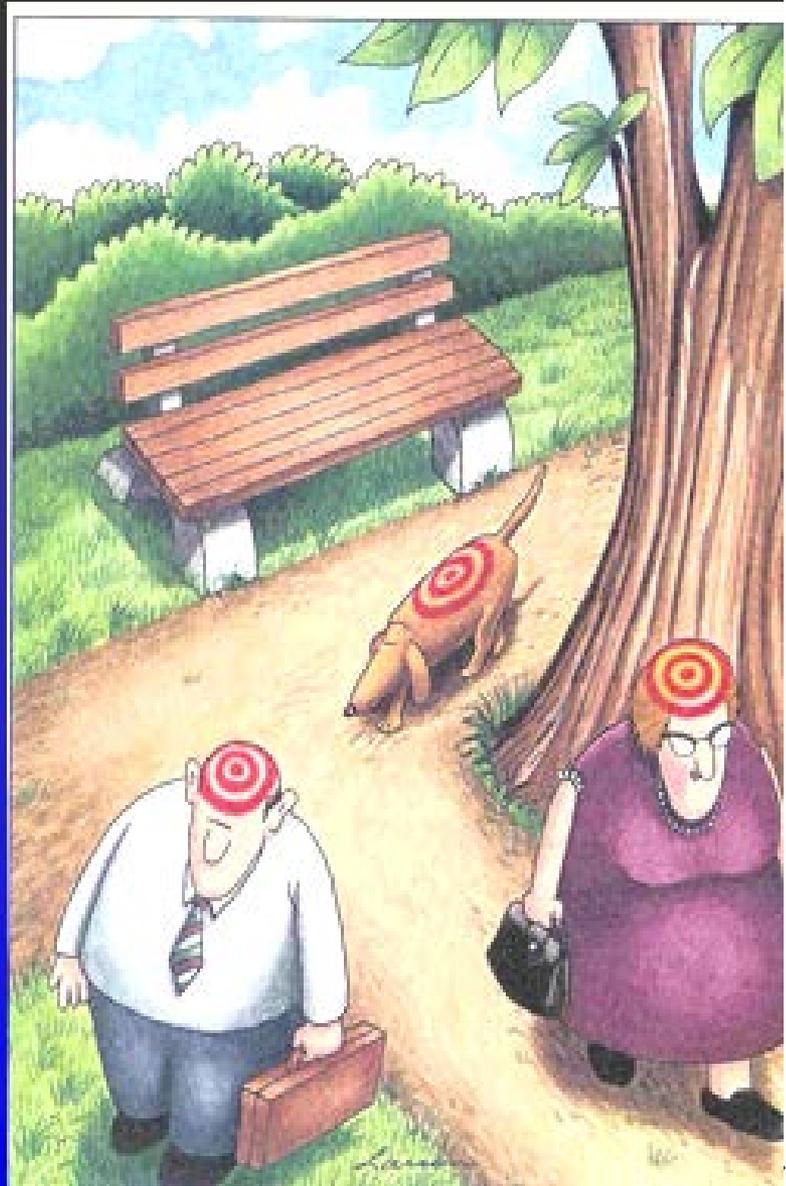
FEDERAL FRAUD AND ABUSE LAWS

- False Claims Act
 - (31 USC 3729)
- Anti-Kickback Act
 - (42 USC 1320a-7b(b))
- Stark Laws
 - (42 USC 1395 nn & nn(h)(6))
 - HIPAA creates a new category of offenses which includes Health care fraud
- These laws are upheld through a nationwide network of audits, investigations and inspections





HOW Birds SEE the WORLD.....



PEDIATRICIANS AND RISK

- High rates of participation in government Programs- Medicaid, CHIP, TriCare, Federal Employee Program
- Have a high rate of EM billings- more difficult coding rules
- Many pediatricians do not know the CMS documentation rules or have compliance programs
- Now joining larger groups and may “inherit” compliance risk



CODING/BILLING AREAS OF RISK

- EM “Upcoding” - 99214-99215
- Afterhours Care- billing add-ons incorrectly
- Unbundling of comprehensive services- overuse of modifiers which break CCI edits
- Billing services during a global period
- Failure to document time in using time based codes
- Billing for “New” patients who are by definition established in the practice
- Billing 90461 to VFC, or using 90460/1 when the MD does not counsel



DO E&M ELEMENTS CONTRIBUTE TO CARE?

“...the office-visit descriptors and interpretive guidelines emphasize often-irrelevant elements of patients’ clinical histories and examinations, rather than decision-making and care-management activities”

“Studies show that EHRs pay for themselves within a few years and then generate profit partly because of facilitated coding, not greater practice efficiency.”

Berenson et al, NEJM 364; 20 (2011)



COMPLIANCE PROGRAMS

- A comprehensive set of policies and procedures, along with a method of independent verification, to ensure that all applicable laws regulations, and rules of an organization are followed. (i.e. a proactive method to prevent, detect and rectify improper practices)



TERMINOLOGY FOR “GETTING PAID”

Reporting:

- the “billing” of CPT codes to a payer for services rendered so they can be paid or tracked (entered into a database)

Licensure:

- a state entity allowing the provider to perform a service under a “scope of practice” law, act, or regulation

Credentialing:

- certification by a public or private payer defining the services for which the provider will be paid



CURRENT PROCEDURAL TERMINOLOGY (CPT)

- Copyrighted publication by the AMA
- Used as the standard Medicare code set since 1990's
- Tell payers what service was performed by a physician on a given patient on a given date
- Provides common definitions for physician work based on
 - Nature and amount of work
 - Place and type of service
 - Patient's health and age (in some cases)



CPT CODE CATEGORIES

Category I:

- Most commonly used codes for billing for patients services-numeric

Category II:

- Performance improvement or tracking codes pay for performance (P4P) measures
- Alphanumeric

Category III:

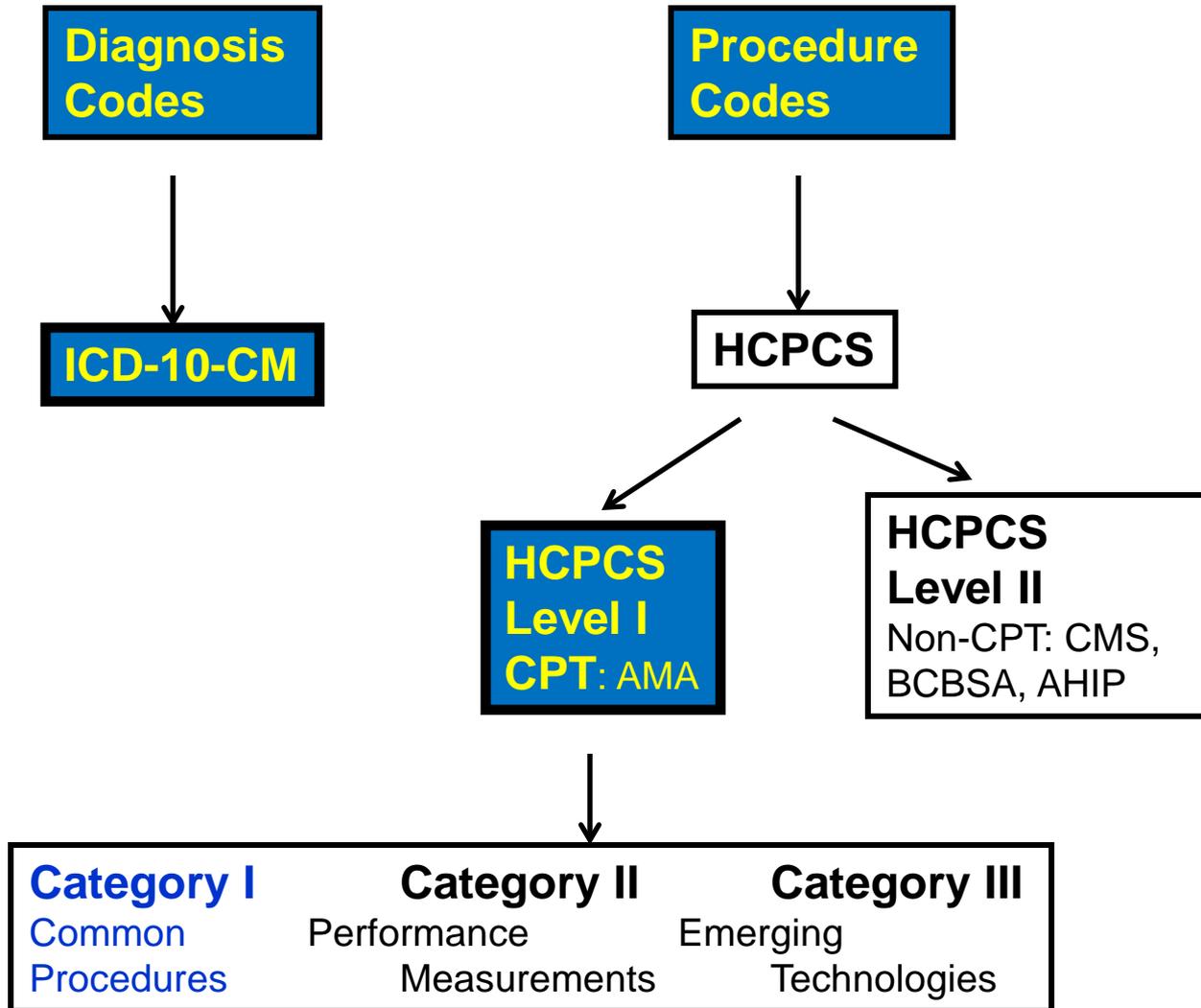
- New procedures and technology
- Can be used for payment, alphanumeric



ICD-10-CM

- Published by the World Health Organization for epidemiological tracking of illness and injury
- The clinical modification in the US is controlled by the ‘cooperating parties’
 - CMS
 - National Center for Health Statistics/CDC
 - American Hospital Association
 - American Health Information Management Association
- Tells Payers about the Medical Necessity of services-the “WHY”





HIPAA-MANDATED STANDARDIZED CODE SETS

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PAYMENT- THE MEDICARE PHYSICIAN **FEE SCHEDULE** **RESOURCE BASED RELATIVE VALUE** **SYSTEM (RBRVS)**

- Is updated each year by CMS- in October -November Federal Register – “Final Rule”
- Is used by the majority of private and public payers (CMS by Year)
- Most CPT codes have a relative value unit - “RVU”
- Each year an updated conversion factor is published
Payment- $rvu \times cf$



RBRVS EXPLAINED

- 2017 -conversion factor = \$35.89
- Payment Example-
- 99213- office visit
- RVU = 2.05
- CF= \$35.89
- So Fee= $2.05 \times \$35.89 = \73.57



NEW CPT FOR 2017

- Published in late September (new vaccine can be July or Jan or AMA website)
- Implementation under HIPAA is 1 Jan 2018
- Good business— query top payers now—
 - Will you cover new code(s) – list
 - What will you pay me ?
 - When will you start paying



CPT SYMBOLS

- New Code

- ▲ Revised Code

- # Re-sequenced code

- ∅ Modifier 51 exempt

Note: A new symbol was added, refer to the next slide



TELEMEDICINE

- Major changes have been made to the 2017 code manual for Telehealth
- CPT now publishes its own code set “free of payer policy”
- Adds telehealth codes via an Appendix



CMS AND TELEMEDICINE

[HTTP://WWW.CMS.GOV/MEDICARE/MEDICARE- GENERAL-
INFORMATION/TELEHEALTH](http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth)

- The primary payment policy of TH services
- Many private payers and Medicaid payers adopt some version of the CMS policy
- Defines most elements- covered services, geographic areas, billing codes/payments, allowed origination sites
- Focus is on expanding Access
- CMS has made recommendation to expand or change for the 2017 Medicare Fee Schedule



CPT AND TELEMEDICINE

- New Appendix (P)
 - This appendix was developed to list all the codes that are applicable to the new *telemedicine modifier*
- New symbol (a star ★)
 - This symbol denotes codes that are listed in appendix P
- New Modifier (95)
 - The new modifier to denote when a service was provided via real-time interactive telecommunications system



TELEMEDICINE- APPENDIX P

Appendix P includes codes for services commonly performed by pediatric physicians, including-

- New and established patient office or other outpatient evaluation and management services **(99201–99205, 99212–99215)**
- New and subsequent hospital care **(99231–99233)**
- Inpatient and outpatient consultations **(99241–99245, 99251–99255)**



TELEMEDICINE- APPENDIX P

Appendix P –other CPT codes

- Prolonged services in the office or outpatient setting



(99354, 99355)

- Individual behavior change interventions **(99406–99409)**

- Transitional care management services **(99495, 99496)**

- Remote real-time interactive video-conferenced critical care codes **(0188T, 0189T)**



TELEMEDICINE – MODIFIER 95

- Telemedicine Service Rendered Via a Real Time Interactive Audio and Video Telecommunications System.
- Modifier **95** may *only be appended* to the services listed in Appendix **P**. Appendix **P** is the list of CPT codes for services that are typically performed face-to-face but may be rendered via a real time (synchronous) interactive audio and video telecommunications system.



TELEMEDICINE – MODIFIER 95*

Telemedicine Service Rendered Via a Real Time Interactive Audio and Video Telecommunications System:

- Synchronous telemedicine service is defined as a ***real-time*** interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional.
- The totality of the communication of information exchanged between the provider or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction
- *Similar to the CMS (HCPCS) G-Code modifier “GT”



TELEMEDICINE – OTHER CODES

- **HCPCS code Q3014- Originating Site**

the telehealth originating site facility fee (*CPT 2017* does not include codes for reporting an originating facility fee)

report for hosting the patient during the telemedicine service (eg, providing conference or examination room, staff, etc to accommodate the telemedicine service).

- **HCPCS code T1014 – For internet line**

Physicians at an originating site may also be able to report the transmission service (eg, cost of telecommunications service) using (telehealth transmission, per minute, professional services bill separately), billing one unit for each minute of service.



HEALTH RISK ASSESSMENT

Code **99420** is deleted! And becomes 96160

- **96160** Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
- **96161** Administration of *caregiver-focused health* risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized Instrument

CMS Fee- \$4.67 for each (96127= \$5.74; 96110 = \$9.69)



2017 – OTHER FLU CODE CHANGES

- Dose Replaces Age
- Effective January 1, 2017, the influenza vaccine codes (**90655–90658**, **90661**, **90674**, and **90685–90688**) will no longer include an age designation but instead will include dosage amounts (eg, 0.5 mL, 0.25 mL).
- Example- **90655** Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, ~~when administered to children 6–35 months of age~~ **0.25 mL dosage**, for intramuscular use



INFLUENZA VACCINE CODES CHANGES

Influenza Codes Revised	2016 (Age of Patient)	Jan 1, 2017 (Dosage)
90655, 90657, 90685, 90687	Age of patient 6-35 mo	0.25mL dosage
90656, 90658, 90686, 90688	> 3 years	0.5mL dosage

New Code – Effective Jan 1

#●90674 Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
(Use for *Flucelvax*)

Remember that the influenza LAIV (Flumist) is not being recommended this year, therefore payers may not cover!



MODERATE SEDATION

- **Ø99143** Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age
- **Ø99144** initial 15 minutes of intra-service time, patient age 5 years or older
- + ● **99145** each additional 15 minutes intra-service time (List separately in addition to code for primary service)



MODERATE SEDATION

- **99148** Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient younger than 5 years of age
- **99149** initial 15 minutes of intra-service time, patient age 5 years or older
 - + ● **99150** each additional 15 minutes intra-service time (List separately in addition to code for primary service)



MODERATE SEDATION

- Intra-service time- face to face time with patient begins when sedation is administered and ends when the procedure ends, patient is stable , and face to face monitoring by physician ends
- Requires monitoring patient response to the sedating agents, including:
 1. Periodic assessment of the patient;
 2. Further administration of agent(s) as needed to maintain sedation;
 3. Monitoring of oxygen saturation, heart rate and blood pressure
- Do not report times of < 10 minutes



PARTIAL EXCHANGE TRANSFUSION

- ● **36456** Partial exchange transfusion, blood, plasma, or crystalloid necessitating the skill of a physician or other qualified health care professional (eg, for hyperviscosity in a neonate).
- For complete exchange transfusions in the neonate, continue to report code **36450**



CMS- 2017 PROPOSED RULE**

BIG NEWS!

- Simplify the chronic care management (“CCM”) billing rules
- Pay for complex CCM (“CCCM”) .
- Pay for care plan development.
- Pay for non-face-to-face prolonged evaluation & management (E/M) services.
- Implement G codes for Behavioral Health Integration (BHI)- behavioral care management and the psychiatric Collaborative Care Model (CoCM)

***confirmed in the Final Rule**



CHRONIC CARE MANAGEMENT: REQUIRED ELEMENTS

CPT 99490

- At least 20 minutes of clinical staff time directed by a physician/QHP, per calendar month, with the following required elements:
- At least 2 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

CMS Fee Schedule- \$32.66

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COMPLEX CHRONIC CARE MANAGEMENT: REQUIRED ELEMENTS

CPT: **99487**

- At least 2 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
- Establish or substantial revision of comprehensive care plan (do not report CCCM if the care plan is unchanged or minimal change)
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

+99489: each additional 30 mi clinical staff time

CMS Fee Schedule- 99487- \$52.76 ; 99489- \$26.56

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CARE MANAGEMENT SERVICES

- Chronic (99490) and Complex Chronic Care (99487, 99489)
- Provided by clinical staff under direction of physician or QHP
- Patient at home, rest home, or assisted living facility
- A plan of care must be documented and shared with the patient and/or caregiver.
- Reported only once per calendar month and only by the physician/QHP who assumes the care management role
- Do not count any clinical staff time on E/M visit day for time that would otherwise be bundled into the E/M



DEVELOPMENT OF ADVANCED CARE PLAN

99497- Advanced Care Planning (advanced directives)

- Power of attorney, living will
 - can report along with same day EM services
 - First 30 minutes, face to face with patient or family/caregiver
- + 99498:** each additional 30 mi clinical staff time



PROLONGED SERVICE WITHOUT DIRECT PATIENT CONTACT- BEFORE OR AFTER DIRECT PATIENT CARE

99358: Prolonged evaluation and management service before and/or after direct patient care; first hour

+99359: each additional 30 minutes (List separately in addition to code for prolonged service)

Service is NOT face-to-face time in the office or outpatient setting nor additional unit/floor time in the hospital

May be reported on a different date than the primary service to which it is related. However, it must relate to a service or patient where (face-to-face) patient care has occurred or will occur.

CMS Fee Schedule- 99358 is \$113.41; for 99359, it is \$54.55



BEHAVIORAL HEALTH INTEGRATION PSYCHIATRIC COLLABORATIVE CARE MODEL (CoCM),

- **“Behavioral health integration”** (BHI) refers to discussions, information sharing, and planning between a primary care provider and a behavioral health specialist relating to the treatment and management of a patient with behavioral health conditions.
- **CoCM** been proven to improve patient outcomes.
- 3 HCPCS G codes describe the requirements for initial and subsequent CoCM involving a behavioral healthcare manager working in consultation with a psychiatric consultant under the direction of the patient’s treating physician (typically primary care.
- A new code for care management services for behavioral health conditions. With the exception of the qualifying diagnosis of behavioral conditions , the billing requirements for GPPPX are the same as those for chronic care management 99450.



BEHAVIORAL HEALTH INTEGRATION PSYCHIATRIC COLLABORATIVE CARE MODEL (CoCM),

- **G0502 –Initial Psych Care Management-first 70 minutes in first month**
 - CMS Fee Schedule- \$ 142.85
- **G0503- Subsequent Psych Care Management- first 60 minutes of second month**
 - CMS Fee Schedule- \$ 126.33
- **G0504- Additional 30 minutes Psych Care Management in a calendar month**
 - CMS Fee Schedule- \$ 66.04



BEHAVIORAL HEALTH INTEGRATION PSYCHIATRIC COLLABORATIVE CARE MODEL (CoCM)

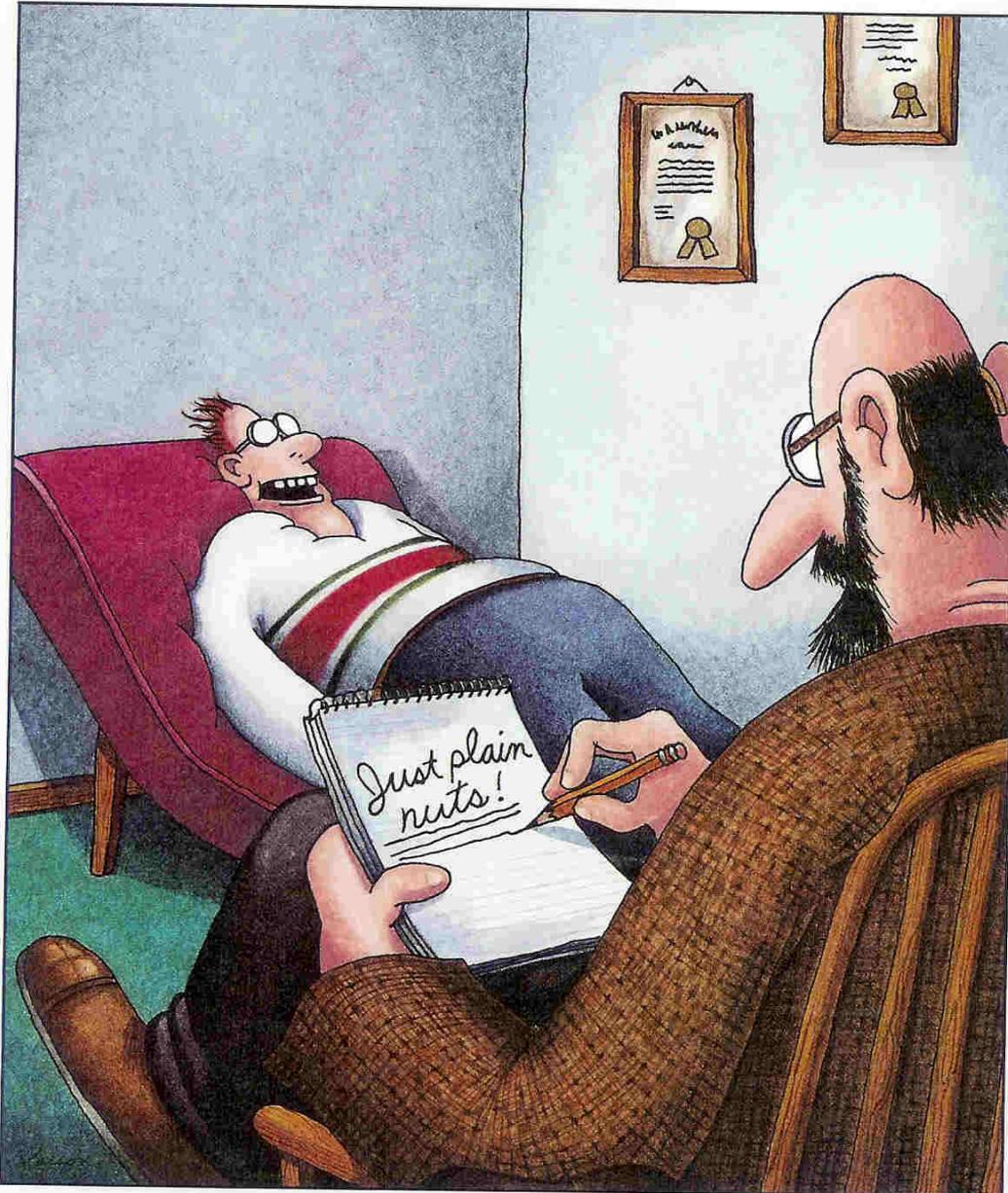
- **G0502 –Initial Psych Care Management-first 70 minutes in first month**
 - Patient outreach and engagement by the treating physician
 - Initial assessment of the patient and development of an individualized treatment plan
 - Review of the treatment plan by a psychiatric consultant and modification of the plan if recommended
 - Entry of the patient in a registry, follow-up tracking, and participation in weekly caseload consultation with the psychiatric consultant
 - Brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies



BEHAVIORAL HEALTH INTEGRATION PSYCHIATRIC COLLABORATIVE CARE MODEL (CoCM),

- **G0507**- care management services for behavioral health conditions-at least 20 minutes of clinical staff time per calendar month
 - With the exception of the qualifying diagnosis of behavioral conditions , the billing requirements for G0507 are the same as those for chronic care management 99450.
 - Initial assessment or follow-up monitoring, including validated rating scales
 - Behavioral health care planning relating to behavioral/psychiatric problems
 - Facilitating and coordinating care
 - Continuity of care with a designated member of the care team
- CMS Fee Schedule- \$ 32.66





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EXISTING EM CODES

- Evaluation and Management- Office
- EM- Time- Prolonged services
- Preventive Medicine Pearls



EM- OFFICE- 99201-99215 CMS EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES

- EM Documentation Guidelines
 - Centers for Medicare and Medicaid Services (CMS)
 - » formerly Health Care Finance Administration (HCFA)
 - Have become the de facto industry standard
 - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>



CMS AND CLINICAL PRESENTATION

FOUR PRINCIPLES

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.

It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.

The volume of documentation should not be the primary influence upon which a specific level of service is billed.

Documentation should support the level of service reported.

Medicare Claims Processing Manual 30.6.1(A)



CMS AND MEDICAL NECESSITY

“....no payment may be made under Part A or Part B for any expenses incurred for items or services, which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” **(Medicare definition of medical necessity under Title XVIII of the Social Security Act, section 1862 (a)(1)(a))**

Thus, the patient’s clinical presentation:

- **Guides the level of history, exam, and decision-making for E/M**
- **Supports the medical necessity and reasonableness of the level of service billed**



TIME-BASED E/M CODING

- When counseling or coordination of care dominates (ie, >50%) an E/M service, you shall report based on time and NOT key components.
- If reporting based on time, your key components will *not* matter (in terms of *CPT* reporting).



TIME-BASED E/M CODING

TYPICAL TIMES

EM Code	Typical Time	Min Time (over half way up)
• 99201-	10 m	NA
• 99202-	20 m	16 m
• 99203-	30 m	26 m
• 99204-	45 m	38 m
• 99205-	60 m	53 m
• 99211-	5 min	NA
• 99212-	10 m	8 m
• 99213-	15 m	13 m
• 99214-	25 m	21 m
• 99215-	40 m	33 m



HOW DO YOU SELECT A CODE LEVEL BASED ON TIME?

- you spent 33 actual minutes counseling a teen about birth control
- 33 minutes is closer to the typical time of 40 min. for a 99215 than to the typical time of 25 min. for 99214



MORE TIME! PROLONGED SERVICES WITH DIRECT PATIENT CONTACT

- Designated as add-on (+) codes
- Can be used in the outpatient setting (99354-99355) or the inpatient/observation setting (99356-99357)



PROLONGED SERVICES WITH DIRECT PATIENT CONTACT

- Use only when the physician spends a minimum of 30 minutes face-to-face with the patient (outpatient) or on the unit/floor (inpatient/observation) beyond the typical time listed in the E/M service code.
- Can be used when reporting your E/M service based on time or key components.
- If reporting your E/M service based on time, prolonged services may only be used on the highest level code in the code set (eg, **99205**, **99215**, **99223**).



PROLONGED SERVICES WITH DIRECT PATIENT CONTACT

	Minimum Time Required	Use in Conjunction With
99354 Outpt.	30-74 min beyond typical time CMS- \$124.34	Appropriate outpatient E/M service
+99355	75 min (use for each additional 30 min) CMS- \$93.82	99354
99356 InPatient	30-74 min beyond typical time CMS- \$93.31	Appropriate inpatient/ observation E/M service
+99357	75 min (use for each additional 30 min) CMS- \$93.31	99356



PREVENTIVE MEDICINE SERVICES

New Patient

Initial E/M of a new patient including an age and gender appropriate history and exam, identification of risk factors, ordering of studies/labs, and anticipatory guidance

- 99381** Age < 1 year
- 99382** Ages 1 – 4 years
- 99383** Ages 5 – 11 years
- 99384** Ages 12 – 17 years
- 99385** Ages 18 – 39 years



PREVENTIVE MEDICINE SERVICES

Established Patient

Periodic re-evaluation and management requiring an age and gender appropriate history and exam, identification of risk factors, ordering of studies/labs, and anticipatory guidance

99391 Age < 1

99392 Ages 1 – 4 years

99393 Ages 5 – 11 years

99394 Ages 12 – 17 years

99395 Ages 18 – 39 years



NEW VS. ESTABLISHED

- A new patient is one who has not received any professional services (defined as face-to-face services reported with a CPT code) from a physician or any physician within the same group practice of the exact same specialty or subspecialty within the past 3 years
- An established patient is one who has received a professional service (defined as a face-to-face service reported with a CPT code) from a physician or any physician within the same group practice of the same specialty or subspecialty within the past 3 years



PREVENTIVE MEDICINE SERVICES

- Includes
 - Age appropriate anticipatory guidance/Risk factor reduction
 - Age appropriate counseling
 - Review of vaccine history
 - Ordering of appropriate labs and diagnostic procedures
 - Developmental surveillance



PREVENTIVE MEDICINE SERVICE

- What they do not include
 - Individual vaccine (component) counseling
 - Administration of vaccines
 - Vaccine products
 - Screenings or other procedures with its own CPT code (eg, Vision screen, hearing screen, developmental screen)
 - Significant and separately identifiable E/M services to address an acute or chronic problem
 - Unrelated procedures (eg, wart removal)



PM SERVICES AND ICD-10-CM

- **Z00.110** Newborn under 8 days old
- **Z00.111** Newborn 8 to 28 days old (NB weight check)
- **Z00.121** Child health examination w/ abnormal findings (Use additional code to identify abnormal findings)
- **Z00.129** Child health examination w/o abnormal findings
- **Z00.00** Adult medical examination w/o abnormal findings
- **Z00.01** Adult medical examination with abnormal findings (Use additional code to identify abnormal findings)



ICD-10-CM

- **Z00.121, Z00.129, Z00.00** and **Z00.01** do not have listed age restrictions.
- Any restrictions listed in the manual are put there by the publisher. Payers may have set limits as well.
- Good age cut off for “child exam” (**Z00.12-**) is 17 years.



ICD-10-CM: ABNORMAL FINDING

- What defines “abnormal finding?”
 - Acute problem found during the exam
 - New chronic condition diagnosed
 - Chronic condition that must be managed during the exam
 - Abnormal screen or lab
- It does not include those chronic conditions that are **stable** or not addressed at the encounter
- It does not require the reporting of a separate E/M service



ICD-10-CM: ABNORMAL FINDINGS

- Examples:
 - Patient with newly diagnosed otitis media
 - Patient with uncontrolled asthma
 - Patient with newly diagnosed hernia
 - Patient with depression that needs to be addressed
 - Patient with an abnormal developmental screen



DEVELOPMENTAL AND BEHAVIORAL SCREENING

96110 developmental screening- milestones

96127 brief emotional behavioral assessment-
depression or ADHD

-Both require scoring and documentation of a
standardized instrument- per instrument- can
bill with multiple units

-Developmental surveillance is not separately
reported- is included in the Preventive Medicine
service itself



ORAL HEALTH- TOPICAL FLUORIDE

- CPT code – **99188** Application of topical fluoride varnish by a physician or other qualified health care professional
- Some Medicaid plans require “D” codes
 - **D1206** – Topical application of fluoride varnish
- AAP Section on Oral Health Resource

www2.aap.org/commpeds/doch/oralhealth/docs/OralHealthReimbursementChart.xlsx



- Four Key Areas of Coding Knowledge
 - EM Codes- New and Old
 - ICD 10- New Codes and New problems
 - **Vaccines and other Procedure**
 - Modifiers



VACCINES/TOXOID PRODUCT CODES MEDICINE SECTION OF CPT

- **90476 – 90749**
 - Identify the specific vaccine product only
 - Use in addition to administration codes

AAP Resource:

- Vaccine Coding Table

<http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Vaccines-Coding-Table.aspx>



IMMUNIZATION PRODUCT CODES

- Book- CPT Manual published each October – New Codes Effective January 1st
- Web- Vaccine product coding changes also appear twice a year on the AMA Web site
 - <http://www.ama-assn.org/ama1/pub/upload/mm/362/vaccinecodes.pdf>
 - January 1
 - July 1
- Codes become “Effective” for use 6 months after appearing
- Symbol “⚡” to indicate FDA^a licensure is pending)



CORRECT IMMUNIZATION CODING

1. Select the Correct CPT^{®a} code for the product - be specific!
2. Add the appropriate vaccine administration code considering patient's age, MD counseling, route and order of administration
3. Correctly link an ICD-10-CM code (diagnosis) to the CPT code for the vaccine and the vaccine administration service



CORRECT IMMUNIZATION CODING

4. Add the code for any E/M services, procedures, or other screening services (lab, x-ray, etc)
5. Attach modifier -25 to the associated E/M code
(Often required by payers for Preventive Medicine Services E/M codes 99381-99395)
6. Frequently check your remittance advice (RA) or explanation of benefits (EOB) for payments



COMBINATION VACCINES AND COMPONENT

- A component refers to an all antigens in a vaccine that prevent disease(s) caused by one organism
- Combination vaccines are those vaccines that contain multiple vaccine components
- Coding is based on the total number of vaccine components given, not the number of vaccines, AND....
- Reflects the additional work of physician vaccine risk/benefit counseling for each component in a combination vaccine



IMMUNIZATION ADMINISTRATION FOR PATIENT THROUGH 18 YEARS OF AGE- PHYSICIAN COUNSELING

90460	via <u>any</u> route of administration, with counseling by physician or other qualified health care professional;
	Use for each vaccine (single or combination)-for combination vaccines use for the first vaccine/toxoid component given.
+90461	– each additional vaccine/toxoid component , and list separately in addition to code for primary procedure (90460)
	For vaccines with multiple components (combination vaccines), report 90460 in conjunction with 90461 for each additional component in a given vaccine



IMMUNIZATION COUNSELING AND DOCUMENTATION

- What constitutes required physician counseling?
 - Vaccine Information Statement (VIS)
- What information can be documented in the medical record?
 - Brief interval medical history
 - Discussion of questions from mandated VIS (Vaccine Information Statement)
 - Screening for vaccine specific indications
 - Determining previous reaction to an immunization
 - Determining allergy to product in the vaccine
 - Determining if special precautions are required for others at home
 - Discussing treatment of local or mild systemic reactions
 - Providing instructions on when to call the office with reactions



IMMUNIZATION ADMINISTRATION CODES NON PHYSICIAN COUNSELING OR TO PATIENT OVER 18 YEARS OF AGE

90471	Immunization administration (percutaneous, intradermal, subcutaneous, intramuscular); one vaccine (single or combination vaccine/toxoid)
+90472	each additional injected vaccine (single or combination)
90473	Immunization administration by intranasal or oral route; one vaccine (single or combination)
+90474	each additional intranasal/oral vaccine (single or combination)



IMMUNIZATION ADMINISTRATION

- Report 90471-74 for immunization administration of any vaccine that is
 - not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family
 - or for administration of vaccines to patients over 18



RULES AND THE “ VFC EXCEPTION”

VFC Coding-

- Can vary by state
- Typical- 90460 for each vaccine given and **DO NOT** allow 90461 for combination vaccines (CMS/VFC Legal interpretation of Federal VFC Regulations)



FROM CPT 2012- “OTHER QUALIFIED HEALTH CARE PROFESSIONAL”

CPT now defines as-

A physician or other qualified health care professional is an individual -

- who by education, training, licensure/regulation, and facility privileging (when applicable), performs a professional service within his/her scope of practice
- independently reports a professional service.
- *These professionals are distinct from ‘clinical staff.’*

*2012 CPT Professional Edition manual.

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FROM CPT 2012- “CLINICAL STAFF ”

CPT now defines this as

- A clinical staff member is a person who-
- works under the supervision of a physician or other qualified health care professional and,
- who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service.
- Other policies may also affect who may report specified services.”

2012 CPT Professional Edition manual.



IMMUNIZATION ADMINISTRATION FOR PATIENT THROUGH 18 YEARS OF AGE

Vaccine	# of Vaccine Components	Immunization Administration Code(s) Reported
HPV	1	90460
Influenza	1	90460
Meningococcal	1	90460
Pneumococcal	1	90460
Td	2	90460 & 90461
DTaP or Tdap	3	90460, 90461, & 90461
MMR	3	90460, 90461,& 90461
DTaP-Hib-IPV (Pentacel)	5	90460, 90461, 90461, 90461& 90461
DTaP-HepB-IPV (Pediatrix)	5	90460, 90461, 90461, 90461 & 90461



IMMUNIZATION ADMINISTRATION 2017 MEDICARE FEE SCHEDULE

- 90460: 0.72 RVU (\$25.84)
- 90461: 0.37 RVU (\$12.92)
- 90471: 0.71 RVU (\$25.84)
- 90472: 0.35 RVU (\$12.92)
- 90473: 0.65 RVU (\$25.84)
- 90474: 0.34 RVU (\$12.92)

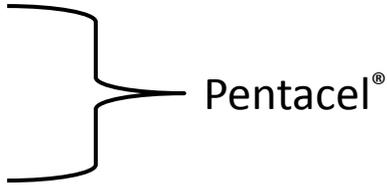


WHAT'S THE DIFFERENCE: PHYSICIAN VS. NURSE COUNSELING DTAP, MMR-V

<i>Physician Counseling</i>		<i>Nurse Counseling</i>	
CPT	RVU	CPT	RVU
90460	0.71 x 2	90471	0.71
90461	0.35 x 5	90472	0.35 x 1
Total	<u>3.17</u>	Total	<u>1.06</u>



4 MONTH-OLD HAVING ROUTINE IMMUNIZATIONS

- DTap
 - Hib
 - IPV
 - PCV
 - RV
- 
- Pentacel[®]

- Pentacel = 5 components
- PCV & RV = 1 component each
- Total of 3 injections

- Provider counseling

- 90460 x 3 + 90461 x 4
 - \$25.86 x 3 + \$12.59 x 4
 - = **\$127.94**

- 90460 x 1 and 90461 x 4 for Pentacel
 - 90460 x 1 for PCV
 - 90460 x 1 for RV

- Nurse counseling

- 90471 x 1 + 90472 x 2
 - \$25.86 x 1 + \$12.59 x 2
 - = **\$51.04**

- 90470 x 1 for first injection
 - 90472 x 2 for additional injections



E/M AND IMMUNIZATION ADMINISTRATION ON SAME DAY

- If a significant separately identifiable E/M service (e.g., office or other outpatient services, preventive medicine services) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes
 - remember -25 modifier



COMMON BILLING ERRORS

- Not billing for every immunization given
- Billing the incorrect product code
- Not billing for each immunization administration service
- Billing the incorrect administration code
- Not linking both the product and administration code to correct diagnosis codes



VACCINES AND ICD-10-CM REPORTING

- For every encounter, ICD-10-CM code **Z23** must be linked to both the product and vaccine administration CPT codes



VACCINES NOT GIVEN

ICD 10 CODES

- Z28.01 Due to of patient acute illness
- Z28.02 Due to chronic illness or condition
- Z28.03 Due to immune compromised state
- Z28.04 Due to allergy to vaccine or component
- Z28.09 Due to other contraindication
- Z28.1 Due to patient decision for reasons of belief or group pressure



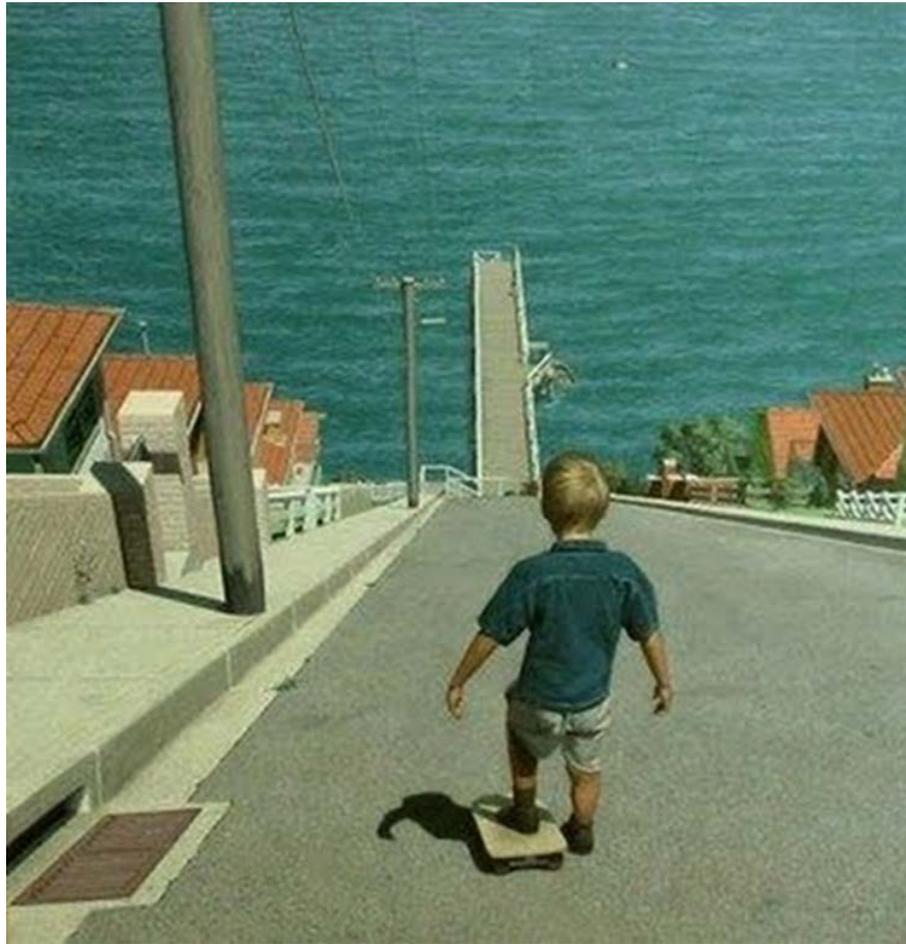
VACCINES NOT GIVEN

ICD 10 CONT'D

- Z28.20 Due to patient decision for unspecified reason
- Z28.21 Due to patient refusal
- Z28.29 Due to patient decision for other reason
- Z28.81 Due to patient having had the disease
- Z28.82 Due to caregiver refusal
- Z28.89 For other reason
- Z28.9 For unspecified reason



ICD 10 CM



ICD-10-CM: NEW CODES FOR 2017

- We have been on an ICD code freeze for the past 5 years
 - Clinical need → code development
 - The October 1, 2016 release is the culmination of 5 years worth of meetings/proposals
 - 1943 New codes
 - 422 Revised codes
 - 305 deleted*
- *codes are not “deleted” in ICD-10-CM, but these 305 codes no longer represent complete codes.



HOW TO IMPROVE CODING AND PAYMENT

Measure your coding profiles

Participate in a practice-based coding education program with regular self auditing of medical records (compliance program)

Always focus on correctly coding

- dollars will follow and you will minimize risk of audits or recoveries

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APPENDIX-ADDITIONAL SLIDES

- **Additional Slides**
 - CMS Telehealth Policy
 - ICD 10 Codes for 2017
 - Modifiers
- **Resources**
 - AAP



CMS AND TELEMEDICINE

[HTTP://WWW.CMS.GOV/MEDICARE/MEDICARE- GENERAL- INFORMATION/TELEHEALTH](http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth)

- The primary payment policy of TH services
- Many private payers and Medicaid payer adopt some version
- Defines most elements- covered services, geographic areas, billing codes/payments, allowed origination sites
- Focus is on expanding Access
- CMS has made recommendation to expand or change in the July Proposed Rule for the 2017 Medicare Fee Schedule



CMS TH POLICY

ORIGINATION SITES

- An **originating site** is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs.
- Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:
 - A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract; or a county outside of a MSA
 - The Health Resources and Services Administration (HRSA) determines HPSAs, and the United States (U.S.) Census Bureau determines MSAs



CMS TH POLICY

ALLOWED ORIGINATION SITES

The originating sites authorized by law are:

- The offices of physicians or practitioners;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics;
- Federally Qualified Health Centers;
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNF); and
- Community Mental Health Centers (CMHC)



CMS TH POLICY

ALLOWED PROVIDER TYPES

DISTANT SITE PRACTITIONERS -Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are:

- Physicians; Nurse practitioners (NP); Physician assistants (PA);
- Nurse-midwives;
- Clinical nurse specialists (CNS);
- Certified registered nurse anesthetists;
- Clinical psychologists (CP) and clinical social workers (CSW). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838; and
- Registered dietitians or nutrition professionals



CMS PAYMENT CONDITIONS

As a condition of payment, you must use –

- an interactive audio and video telecommunications system
- that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site.
- Asynchronous “store and forward” technology is permitted only in Federal telemedicine demonstration programs conducted in Alaska or Hawaii.



CMS PAYMENT CONDITIONS COVERED SERVICES

- **Telehealth consultations, emergency department or initial inpatient HCPCS codes G0425–G0427**
- **Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs HCPCS codes G0406–G0408**
- **Office or other outpatient visits CPT codes 99201–99215**
- **Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days CPT codes 99231–99233**
- **Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days CPT codes 99307–99310**
- **Individual and group kidney disease education services HCPCS codes G0420 and G0421**
- **Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training HCPCS codes G0108 and G0109**



CMS PAYMENT CONDITIONS COVERED SERVICES-CONT'D

- **Individual and group health and behavior assessment and intervention CPT codes 96150–96154**
- **Individual psychotherapy CPT codes 90832–90834 and 90836–90838**
- **Telehealth Pharmacologic Management HCPCS code G0459**
- **Psychiatric diagnostic interview examination CPT codes 90791 and 90792**
- **End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961**
- **Individual and group medical nutrition therapy HCPCS code G0270 and CPT codes 97802–97804**
- **Neurobehavioral status examination CPT code 96116**
- **Smoking cessation services HCPCS codes G0436 and G0437 and CPT codes 99406 and 99407**



CMS PAYMENT CONDITIONS COVERED SERVICES-CONT'D

- Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services HCPCS codes G0396 and G0397
- Annual alcohol misuse screening, 15 minutes HCPCS code G0442
- Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes HCPCS code G0443
- Annual depression screening, 15 minutes HCPCS code G0444
- High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes HCPCS code G0445
- Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes HCPCS code G0446
- Face-to-face behavioral counseling for obesity, 15 minutes HCPCS code G0447
- Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge) CPT code 99495
- Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge) CPT code 99496
- Psychoanalysis (effective for services furnished on and after January 1, 2015) CPT codes 90845



CMS PAYMENT CONDITIONS COVERED SERVICES-CONT'D

- **Family psychotherapy (without the patient present) (effective for services furnished on and after January 1, 2015) CPT code 90846**
- **(effective for services furnished on and after January 1, 2015) CPT code 90847**
- **Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (effective for services furnished on and after January 1, 2015) CPT code 99354**
- **Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (effective for services furnished on and after January 1, 2015) CPT code 99355**
- **Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit (effective for services furnished on and after January 1, 2015) HCPCS code G0438**
- **Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit (effective for services furnished on and after January 1, 2015) HCPCS code G0439**



CMS BILLING AND PAYMENT

GT MODIFIER

- You should submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service
- Use the telehealth modifier GT, “via interactive audio and video telecommunications systems” (for example, 99201 GT).
- By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the beneficiary was present at an eligible originating site when you furnished the telehealth service.
- Medicare pays you the appropriate amount under the Medicare Physician Fee Schedule (PFS) for covered telehealth services.



CMS BILLING AND PAYMENT

GQ MODIFIER

- For Federal telemedicine demonstration programs conducted in Alaska or Hawaii, you should submit claims using the appropriate CPT or HCPCS code for the professional service
- Use the telehealth modifier GQ if you performed telehealth services “via an asynchronous telecommunications system” (for example, 99201 GQ).
- By using the GQ modifier, you are certifying that the asynchronous medical file was collected and transmitted to you at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.
- Medicare pays you the appropriate amount under the Medicare Physician Fee Schedule (PFS) for covered telehealth services.



CMS BILLING AND PAYMENT ORIGINATING SITE Q3014

- Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014
- Pays for the practice expense at the hosting site-check in , facilitator, room

.



CMS PROPOSED RULE – NEW COVERAGE FOR 1-1-17

- Rejected adding- OBV, ER, Psychology testing
 - “there is insufficient evidence that the produces similar diagnoses or therapeutic options as compared to face to face services”
- Add to the list of covered service under TH ,
 - advanced care planning, and
 - Critical Care consultation
 - ESRD related services
- CMS “may” develop a POS for certain telemedicine Services
 - “May” direct use of the distant site POS by the provider of the service, the originating site uses its own POS



CHAPTER 12 – DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE

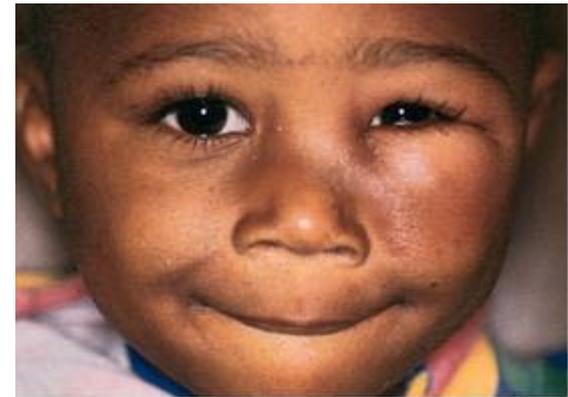
New code added at **L03.21** Cellulitis and acute lymphangitis of face

New Code:

L03.213 Periorbital cellulitis

– Includes preseptal cellulitis

The severity of this condition merited the inclusion of this code



Source: Knoop KJ, Stack LB, Storrow AB, Thurman RJ: The Atlas of Emergency Medicine, 3rd Edition: <http://www.accessmedicine.com>. Copyright © The McGraw-Hill Companies, Inc. All rights reserved.

CHAPTER 16 - CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD

- New Guideline at Categories **P00-P04 Newborn** *affected by maternal factors and by complications of pregnancy, labor, and delivery*
- “These codes are for use when the listed maternal conditions (or birth process) are specified as the cause of confirmed morbidity or potential morbidity which have their origin in the perinatal period (before birth through the first 28 days after birth).”
- *Do not report these codes if the condition has been ruled out (Refer to Z05)*



CH 21 - FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES

- **Z05** Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out

Guideline:

- *This category is to be used for newborns, within the neonatal period (the first 28 days of life), who are suspected of having an abnormal condition unrelated to exposure from the mother or the birth process, but without signs or symptoms, and which, after examination and observation, is ruled out.*
- **Excludes2:** newborn observation for suspected condition, related to exposure from the mother or birth process (**P00-P04**)
- Example: observing for development of Neonatal Abstinence Syndrome; observing for development of sepsis.



ICD-10-CM UPDATES

- Remember to begin using these new codes on and after Oct 1
- Do not report “deleted” codes – be sure that you have the full code if submitting for a condition where the code has been deleted
- In a sense, deleted codes turn into more specific new codes



“DELETED” CODES

- Example: Idiopathic acute pancreatitis
- Prior to Oct 1, reported as:
 - **K85.0** (Idiopathic acute pancreatitis)
- On Oct 1, 5th digit required. **K85.0** will be denied as invalid code
- ICD-10-CM formatting:

K85.0 Idiopathic acute pancreatitis

K85.00 Idiopathic acute pancreatitis without necrosis or infection

K85.01 Idiopathic acute pancreatitis with uninfected necrosis

K85.02 Idiopathic acute pancreatitis with infected necrosis



CH 1 - CERTAIN INFECTIOUS AND PARASITIC DISEASES

New code added for Zika virus



- **A92.5 Zika virus disease**

Zika virus fever, Zika virus infection, Zika NOS

- The AAP is developing new codes for perinatal exposure and perinatal infection as well as an “exposure” code outside of the perinatal period.
- Current, for exposure: **P00.2** (Newborn affected by maternal infectious and parasitic diseases)



OBSERVATION & EVALUATION OF NEWBORN

Z05.6 Observation and evaluation of NB for suspected genitourinary condition R/O

Z05.71 suspected skin/subcutaneous tissue R/O

Z05.72 suspected musculoskeletal condition R/O

Z05.73 suspected connective tissue condition R/O

Z05.8 other specified suspected condition R/O

Z05.9 unspecified suspected condition R/O



OBSERVATION & EVALUATION OF NEWBORN

- Z05.0** Observation and evaluation of newborn for suspected cardiac condition ruled out
- Z05.1** suspected infectious condition R/O
- Z05.2** suspected neurological condition R/O
- Z05.3** suspected respiratory condition R/O
- Z05.41** suspected genetic condition R/O
- Z05.42** suspected metabolic condition R/O
- Z05.43** suspected immunologic condition R/O
- Z05.5** suspected gastrointestinal condition R/O



CHAPTER 16 - CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD

- New codes were added at **P05.0** *Newborn light for GA* and **P05.1** *Newborn small for GA*

New Codes:

- **P05.09** Newborn light for gestational age, 2,500 grams and over (wt < 10%tile)
- **P05.19** Newborn small for gestational age, other (wt. and ht. <10%tile)
(Newborn small for gestational age, 2500g and over)



CH 17 - CONGENITAL MALFORMATIONS, DEFORMATIONS AND CHROMOSOMAL ABNORMALITIES

Other new codes:



- **Q82.6** Congenital sacral dimple
 - Parasacral dimple
- **Q87.82** Arterial tortuosity syndrome

CH 21 - FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES

New Codes for Prophylactic Services:

Z29.11 Encounter for prophylactic immunotherapy for respiratory syncytial virus (RSV)

Z29.12 Encounter for prophylactic antivenin

Z29.13 Encounter for prophylactic Rho(D) immune globulin

Z29.14 Encounter for prophylactic rabies immune globulin

Z29.3 Encounter for prophylactic fluoride administration

Z51.6 Encounter for desensitization to allergens



CH 21 - FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES

New family history codes:

- **Z83.42** Family history of familial hypercholesterolemia
- **Z84.82** Family history of sudden infant death syndrome



CH 7 – DISEASES OF THE EYE AND ADNEXA

- **Amblyopia, suspect**
- **H53.041** - Amblyopia suspect, right eye
- **H53.042** - Amblyopia suspect, left eye
- **H53.043** - Amblyopia suspect, bilateral
- These codes were created to be able to show that the physician is concerned that the child has significant factors for amblyopia and wants to ensure proper follow-up.



CH 8 – DISEASES OF THE EAR AND MASTOID PROCESS

- New Codes at **H90.A**
 - **H90.A11** - Conductive hearing loss, right ear, with restricted hearing on the contralateral side
 - **H90.A12** - left ear
 - **H90.A21** - Sensorineural hearing loss, right ear, with restricted hearing on the contralateral side
 - **H90.A22** - left ear
 - **H90.A31** - Mixed conductive and sensorineural hearing loss, right ear, with restricted hearing on the contralateral side
 - **H90.A32** - left ear



CHAPTER 9 – DISEASES OF THE CIRCULATORY SYSTEM

- A new category was added
- **I16** *Hypertensive crisis*

New Codes:

- **I16.0** - Hypertensive urgency
- **I16.1** - Hypertensive emergency
- **I16.9** - Hypertensive crisis, UNSPEC



CHAPTER 11 – DISEASES OF THE DIGESTIVE SYSTEM

- At **K02** *Dental caries* – a new includes note was added as follows

Includes: caries of dentine

early childhood caries

pre-eruptive caries

recurrent caries

Z29.3- prophylactic fluoride administration



CHAPTER 11 – DISEASES OF THE DIGESTIVE SYSTEM

- New codes were added under **K52.2** *Allergic and dietetic gastroenteritis and colitis*
- **K52.21** - Food protein-induced enterocolitis syndrome
- **K52.22** - Food protein-induced enteropathy
- **K52.29** - Other allergic and dietetic gastroenteritis and colitis



CHAPTER 11 – DISEASES OF THE DIGESTIVE SYSTEM

- New codes added at **K58** *Irritable bowel syndrome*

New Codes:

- **K58.1** Irritable bowel syndrome with constipation
- **K58.2** Mixed irritable bowel syndrome
- **K58.8** Other irritable bowel syndrome



CHAPTER 11 – DISEASES OF THE DIGESTIVE SYSTEM

- New codes added at **K59.0** *Constipation*

New Codes:

- **K59.03** Drug induced constipation
 - Use Additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)
- **K59.04** Chronic idiopathic constipation
 - Includes functional constipation



CH 14 – DISEASES OF THE GENITOURINARY SYSTEM

- New subcategory and codes added at **N50.8** *Other specified disorders of male genital organs*
- New Subcategory: **N50.81** *Testicular pain*

New Codes:

- **N50.811** Right testicular pain
- **N50.812** Left testicular pain
- **N50.819** Testicular pain, unspecified
- **N50.82** Scrotal pain
- **N50.89** Other specified disorders of the male genital organs



CH 20 - EXTERNAL CAUSES OF MORBIDITY

- **W26.2** Contact with edge of stiff paper
paper cut
- **W26.8** Contact with other sharp object(s), not elsewhere classified
- Contact with tin can lid
- **W26.9** Contact with unspecified sharp object(s)



CH 20 - EXTERNAL CAUSES OF MORBIDITY

- **X50.0** Overexertion from strenuous movement or load
 - Lifting heavy objects or weights
- **X50.1** Overexertion from prolonged static or awkward postures
 - Prolonged or static bending
 - Prolonged or static kneeling
 - Prolonged or static reaching
 - Prolonged or static sitting
 - Prolonged or static standing
 - Prolonged or static twisting
- **X50.3** Overexertion from repetitive movements
- **X50.9** Other and unspecified overexertion or strenuous movements or postures



HEARING SCREEN

- Hearing testing - Select picture **92583**
- Hearing testing – Puretone **92552**
- OAE Screening **92558***
- OAE limited evaluation **92587***

*Coverage may be limited by age and defined by individual payers.



VISION SCREEN

- Visual Acuity
 - **99173** Screening test of visual acuity, quantitative, bilateral
- Photoscreening
 - **99174** Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with remote analysis and report
 - **99177** with on-site analysis



LABORATORY SERVICES

• Hemoglobin	85018
• HIV-1 Antibody	86701
• HIV Confirmation (Western Blot)	86689
• Lead	83655
• Lipid Panel	80061
• Total Cholesterol	82465*
• HDL-C	83718*
• Chlamydia culture	87110
• Chlamydia (rapid)	87810
• Gonorrhea (rapid)	87850
• Gonorrhea (direct probe technique)	87590

Venipuncture/finger stick **36415/36416**

*Do not report **82465** and/or **83718** if ordering a lipid panel (**80061**)

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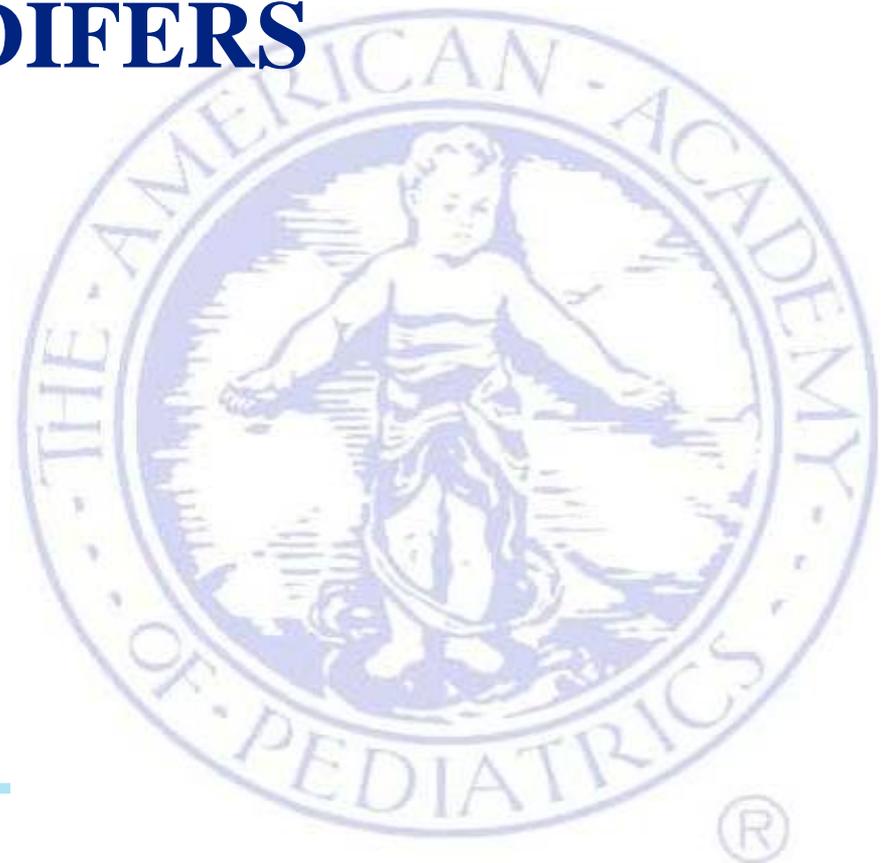


PPD/TB TESTING: 86580

- Remember:
 - Applying the test-bill only **86580**- There is no additional code for the administration like vaccines, it is included in **86580**
 - Reading the test-
 - If the patient returns to have it read, this service is not included and can be reported separately
 - For a nurse-only visit, you can report **99211** and **Z11.1** (for a negative screen)
 - For a positive screen link the E/M service to **R76.11** (positive PPD)

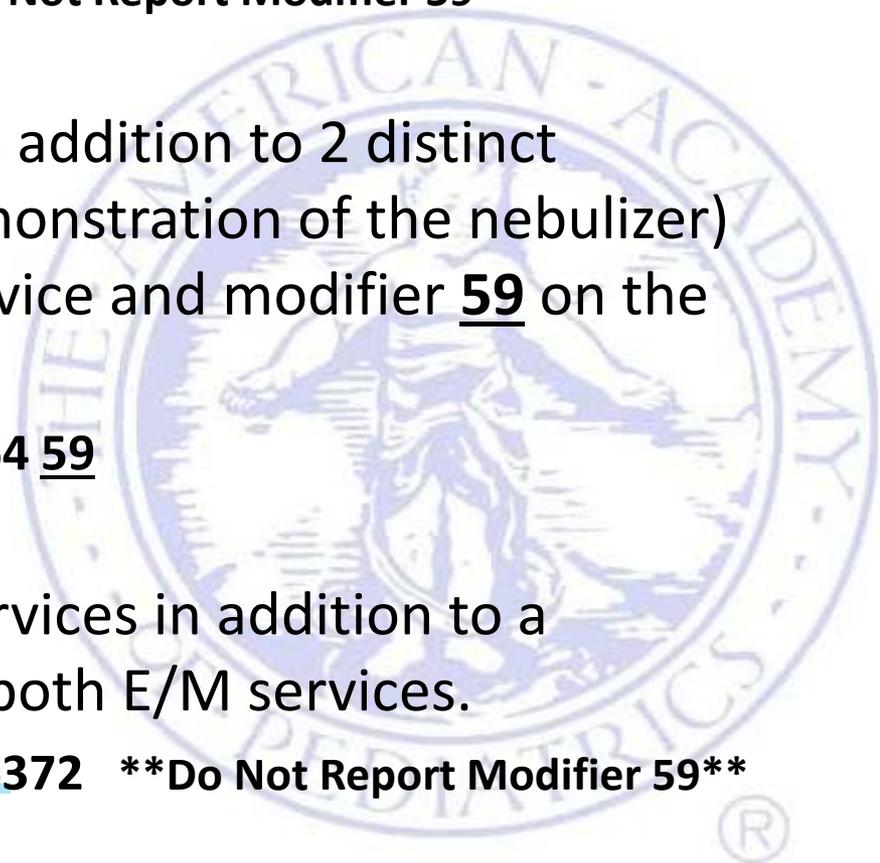


E/M MODIFIERS



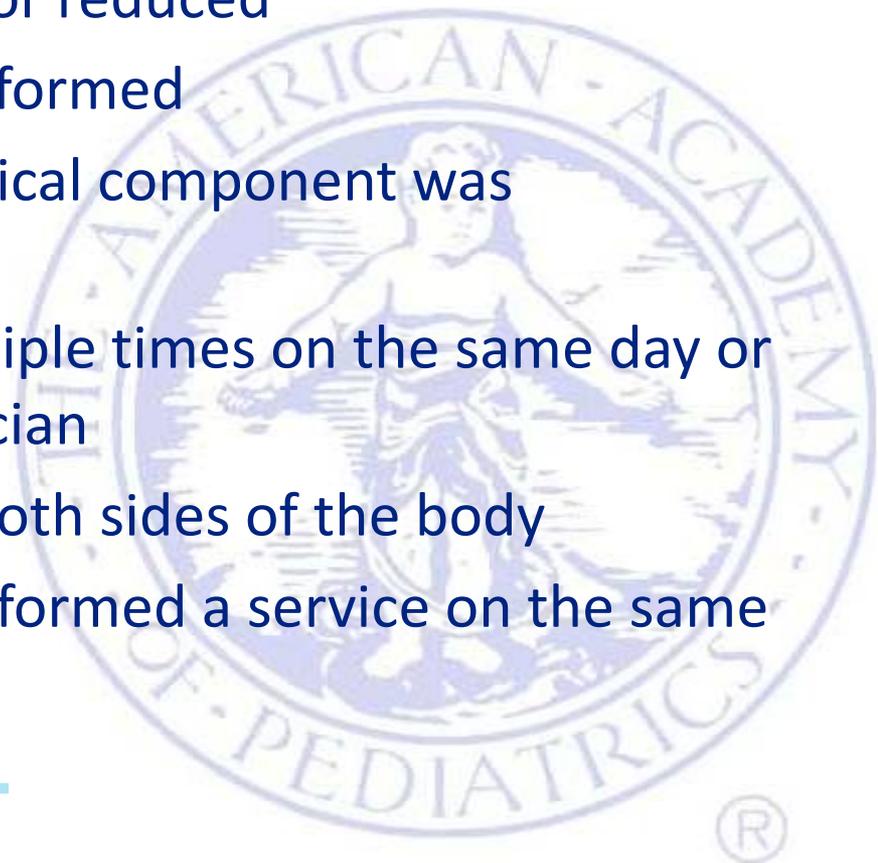
MODIFIER 25 VS 59

- When billing out an E/M service with a significant and separately identifiable procedure always report modifier 25 on the E/M service and nothing on the procedure.
 - Example: **99214 25** and **96372** **** Do Not Report Modifier 59****
- When billing out an E/M service in addition to 2 distinct procedures (eg, nebulizer and demonstration of the nebulizer) report modifier 25 on the E/M service and modifier 59 on the lesser procedure.
 - Example: **99214 25** **96460** and **94664 59**
- When billing out 2 distinct E/M services in addition to a procedure, report modifier 25 on both E/M services.
 - Example: **99393 25** **99213 25** and **96372** ****Do Not Report Modifier 59****



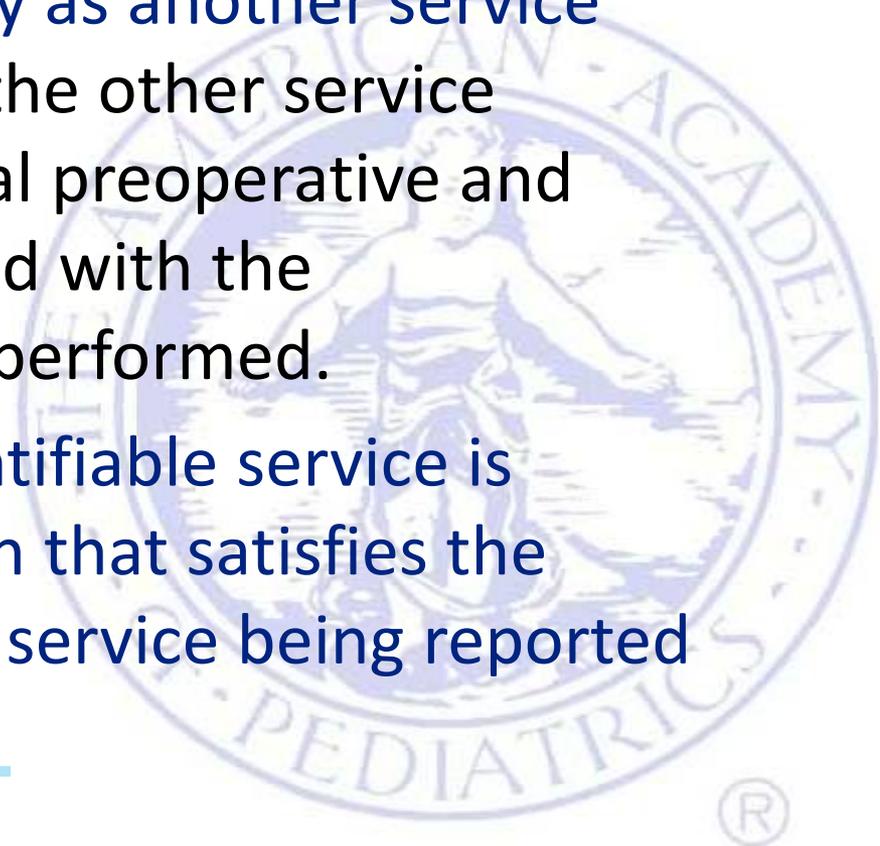
MODIFIERS: UTILITY

- Modifiers are used as a method to indicate the following:
 - A service has been increased or reduced
 - Only part of a service was performed
 - Only a professional or a technical component was performed
 - A service was performed multiple times on the same day or done by more than one physician
 - A service was performed on both sides of the body
 - More than one physicians performed a service on the same patient /same day



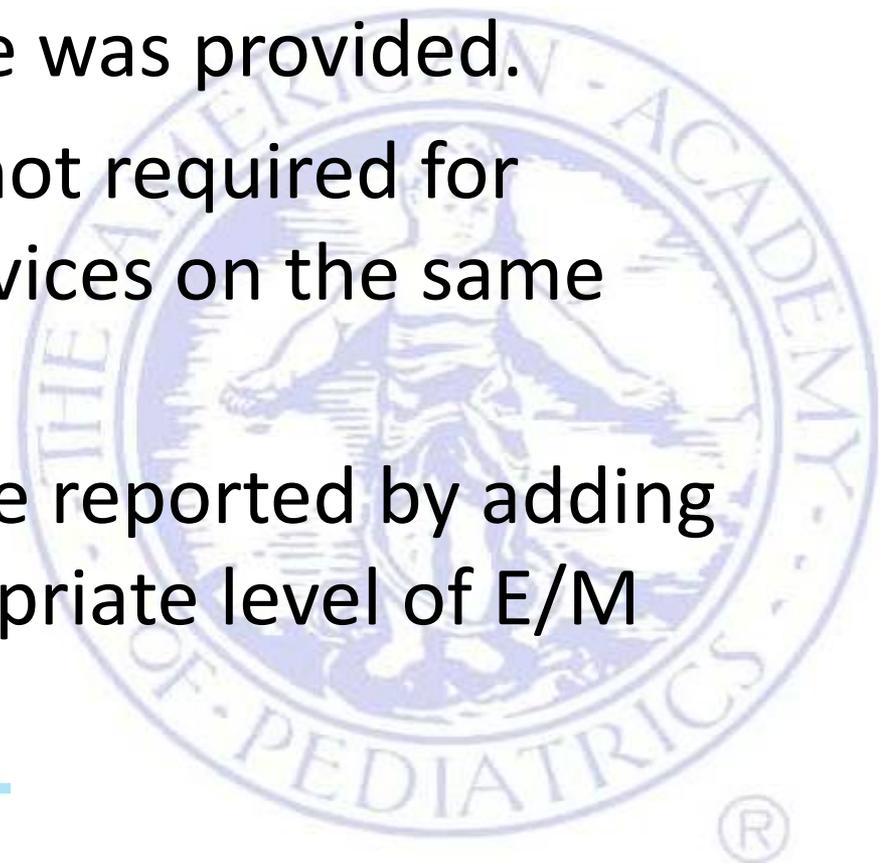
25 - SEPARATE E/M SERVICE SAME PROVIDER /SAME DAY

- Significant, separately identifiable E/M service by the *same* physician or other qualified health care professional on the same day as another service which is above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure/service that was performed.
- A significant, separately identifiable service is supported by documentation that satisfies the relevant criteria for the E/M service being reported and medical necessity.



MODIFIER 25

- The E/M service may be prompted by the (same) symptom or condition for which the procedure and/or service was provided.
- Different diagnoses are not required for reporting of the E/M services on the same date.
- This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.



MODIFIER 25 EXAMPLES: E/M SERVICES WITH SEPARATE PROCEDURES

URI with Nasal Foreign Body

<i>CPT/Modifier</i>	<i>ICD-10-CM</i>
99213 25	J06.9 URI
30300 Foreign body removal, nose	T17.1XXA Foreign body, nose

Earache with Cerumen Removal by Irrigation

<i>CPT/Modifier</i>	<i>ICD-10-CM</i>
99213 25	H65.06 Acute serous otitis media, bilateral
69209 Cerumen Removal, Irrigation	H61.21 Impacted Cerumen, right ear

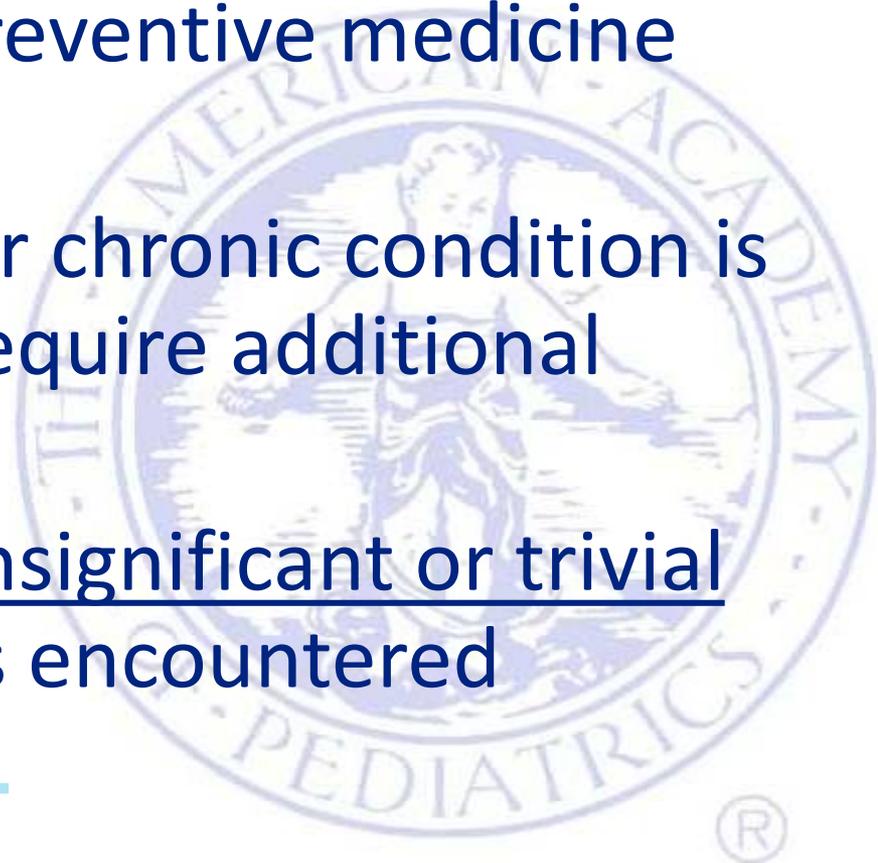
Urinary Tract Infection with Catheterization

<i>CPT/Modifier</i>	<i>ICD</i>
99213 25	N39.0 UTI
51701 Catheterization	N39.0 UTI



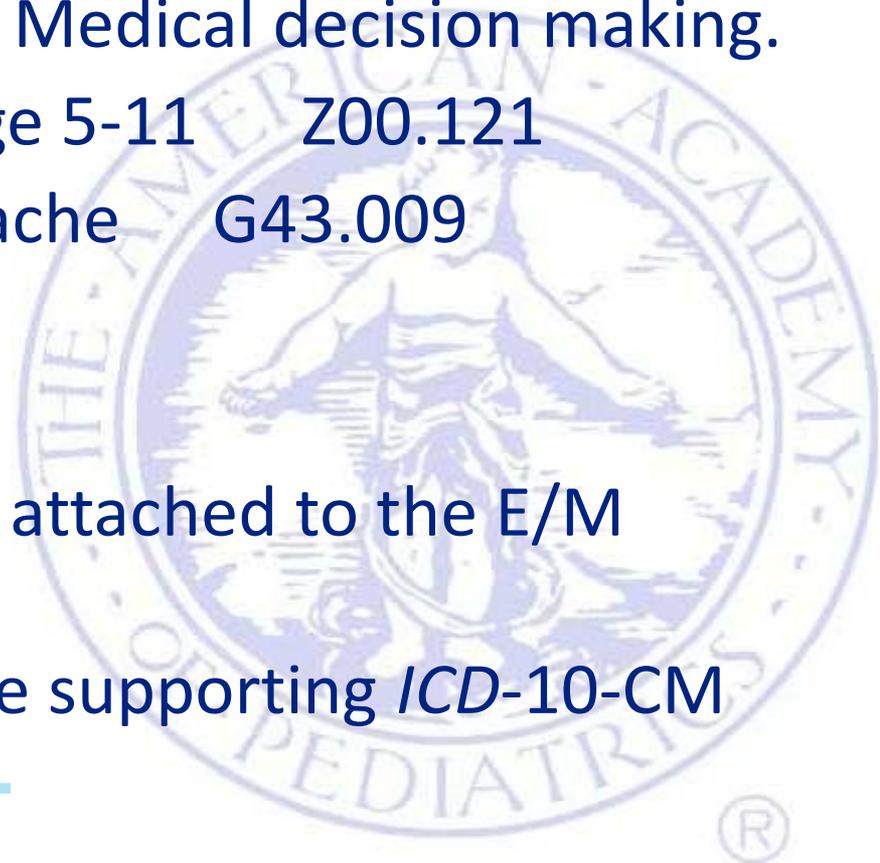
MODIFIER 25 – E/M SERVICES WITH A PREVENTIVE MEDICINE SERVICE

- To be used when an abnormality(ies) is encountered or a pre-existing problem needs to be addressed at a preventive medicine service.
- Problem/abnormality or chronic condition is significant enough to require additional work.
- 25 is not to be used if insignificant or trivial problem/abnormality is encountered



MODIFIER 25 EXAMPLE: E/M SERVICES WITH A PREVENTIVE MEDICINE (PM) SERVICE

- An 11-year old established patient has a well visit- hx reveals a recurrent throbbing headaches – dx requires additional history, exam and Medical decision making.
 - 99393 PM service , age 5-11 Z00.121
 - 99214 25 migraine headache G43.009
- Key considerations
 - The 25 Modifier always is attached to the E/M service, not the PM
 - Link both *CPT* codes to the supporting *ICD-10-CM* diagnosis codes



MODIFIER 25

Answer these 3 questions before reporting an EM with the PM service

1. Significant-

Would this have possibly required a separate encounter anyway?

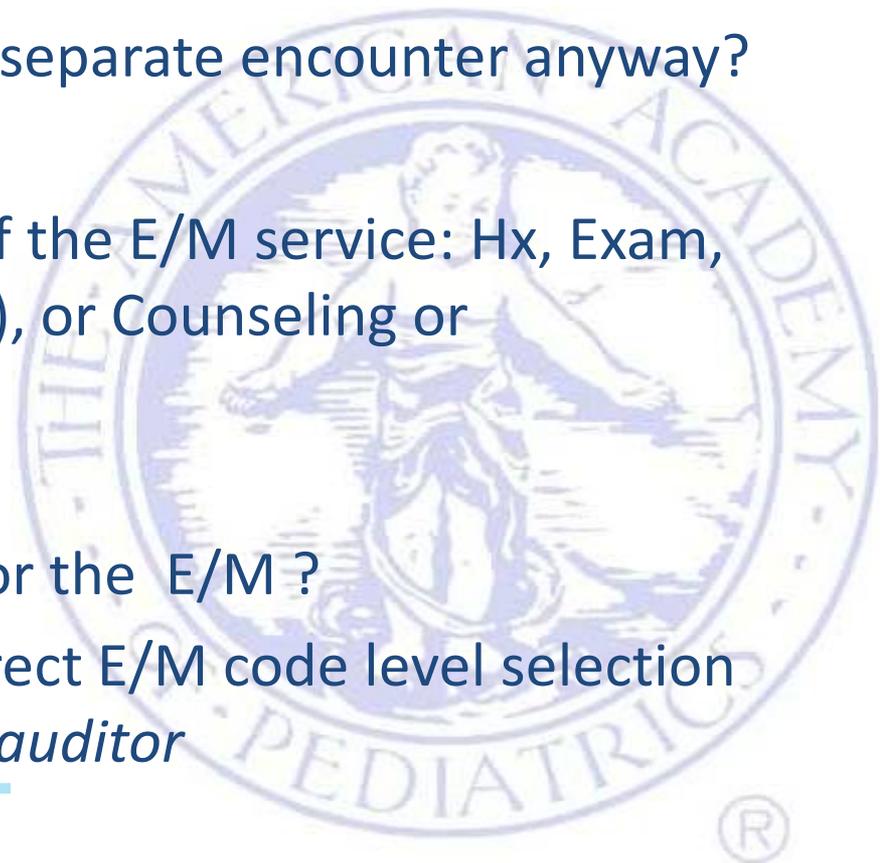
2. Separately identifiable -

Did it require the key components of the E/M service: Hx, Exam, and Medical Decision Making(MDM), or Counseling or Coordinating Care Time?

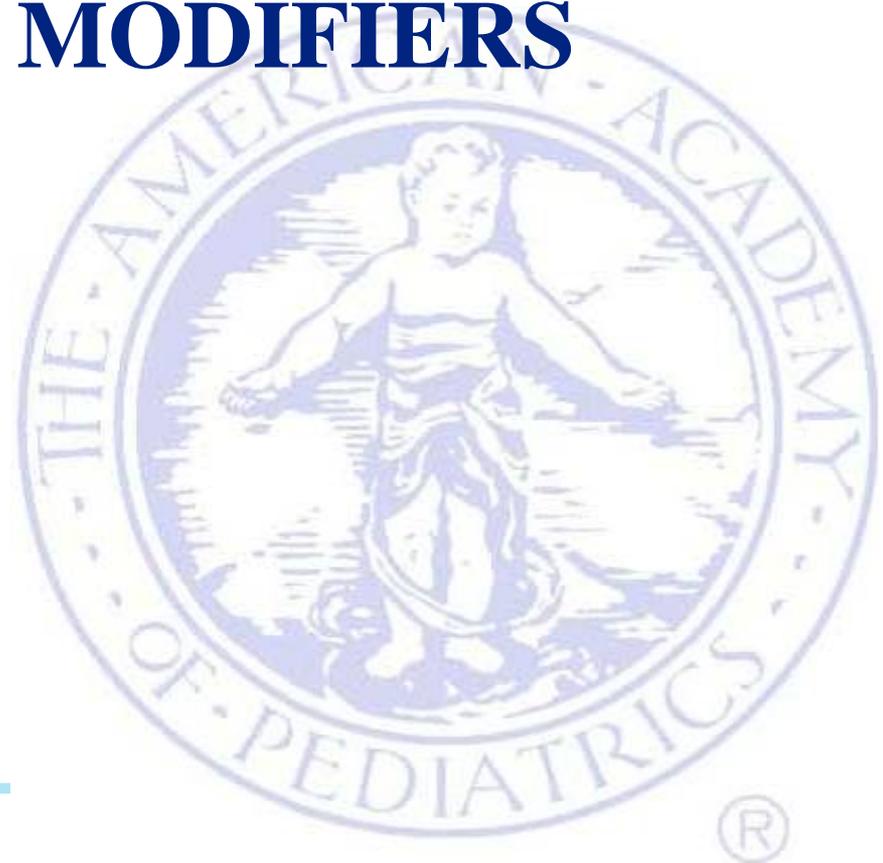
3. Documentation-

Is there additional documentation for the E/M ?

Separate documentation makes correct E/M code level selection easier - for the provider and for the *auditor*



PROCEDURAL MODIFIERS



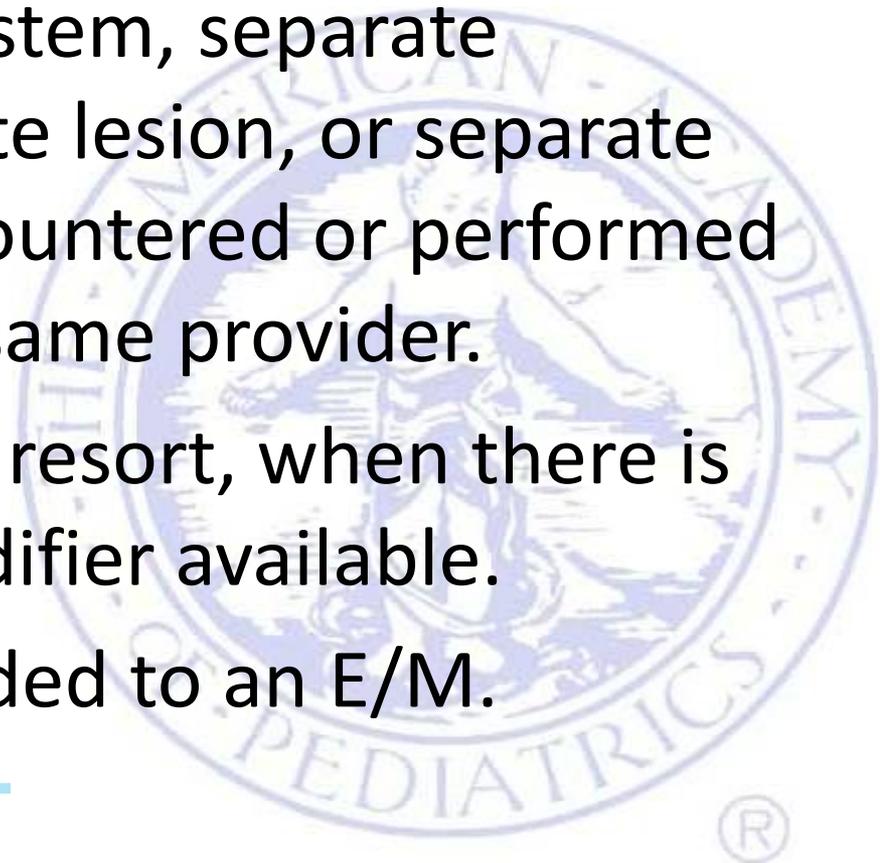
59 - DISTINCT PROCEDURAL SERVICE

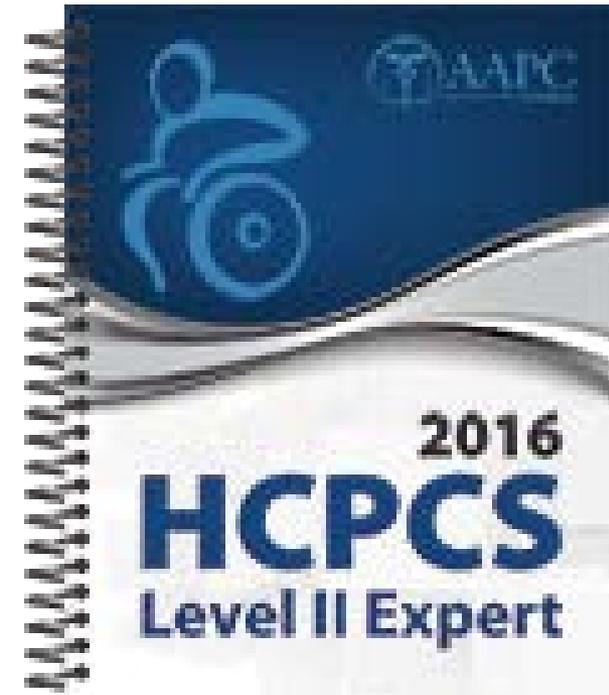
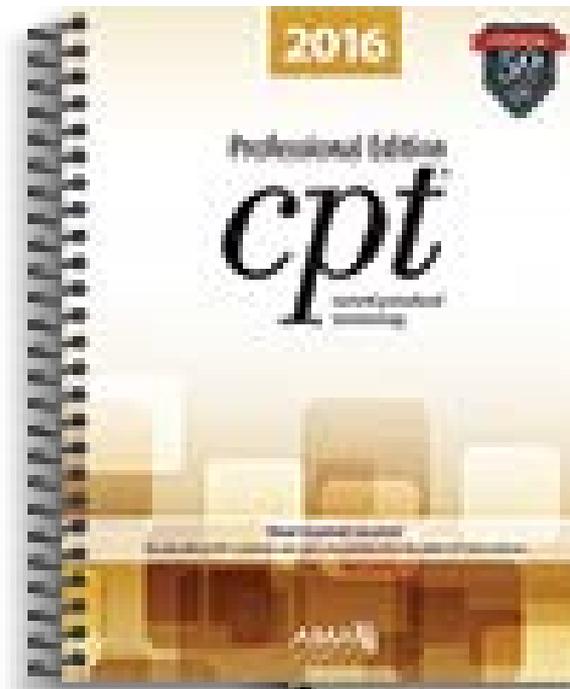
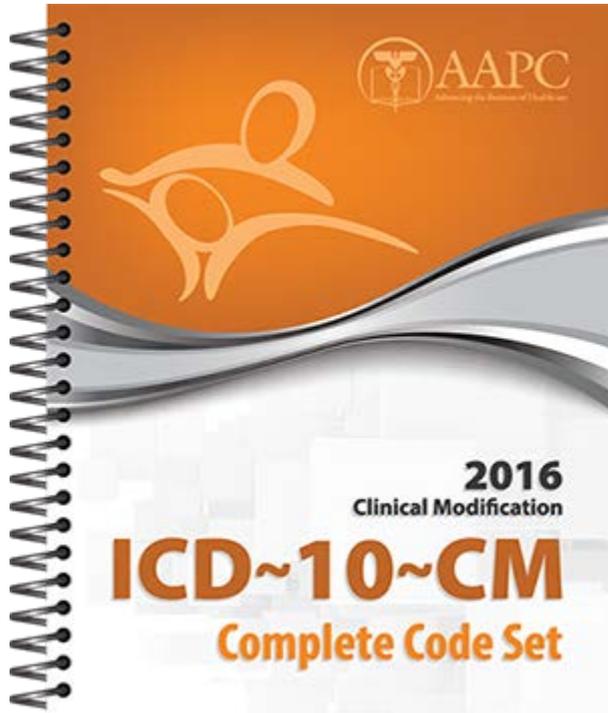
- Modifier **59** is used to identify procedure/services, other than E/M, that are not normally reported together, but are appropriate under the circumstances.
- After modifier 25, it's the most commonly reported modifier



MODIFIER 59 – DISTINCT PROCEDURAL SERVICE

- Documentation must support either a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same provider.
- Use modifier 59 as a last resort, when there is no other descriptive modifier available.
- Should NEVER be appended to an E/M.



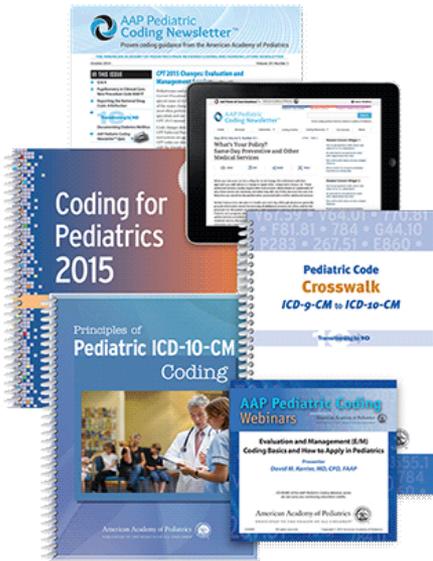


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Stay current with all the latest in pediatric coding and compliance.

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In its 21th edition, this signature coding publication complements standard coding manuals with proven pediatric-specific documentation and billing solutions.

Pediatric Code Crosswalk ICD-9-CM to ICD-10-CM

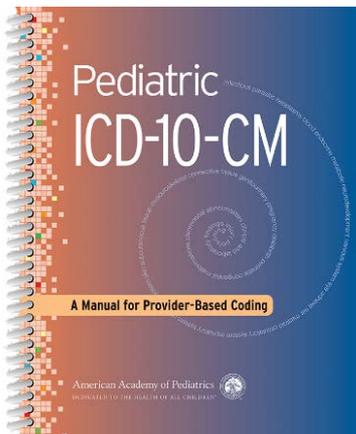
Simplify *ICD-9-CM* coding AND prepare for *ICD-10-CM* transition!

Principles of Pediatric ICD-10-CM Coding

A practical desktop handbook and an efficient training tool, it provides a wealth of pediatric-focused knowledge for accurate diagnosis coding.

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In its first edition, this manual will assist pediatric providers, coders, and billing staff with a condensed version of the *ICD-10-CM* manual so that they can confidently manage the transition with accurate pediatric diagnostic coding.



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AAP CODING RESOURCES

- Coding At the AAP Site



– One stop shop for all coding related resources from the AAP!

- AAP Coding Hotline

aapcodinghotline@aap.org



CHANGE...IS CONSTANT IN HEALTH CARE

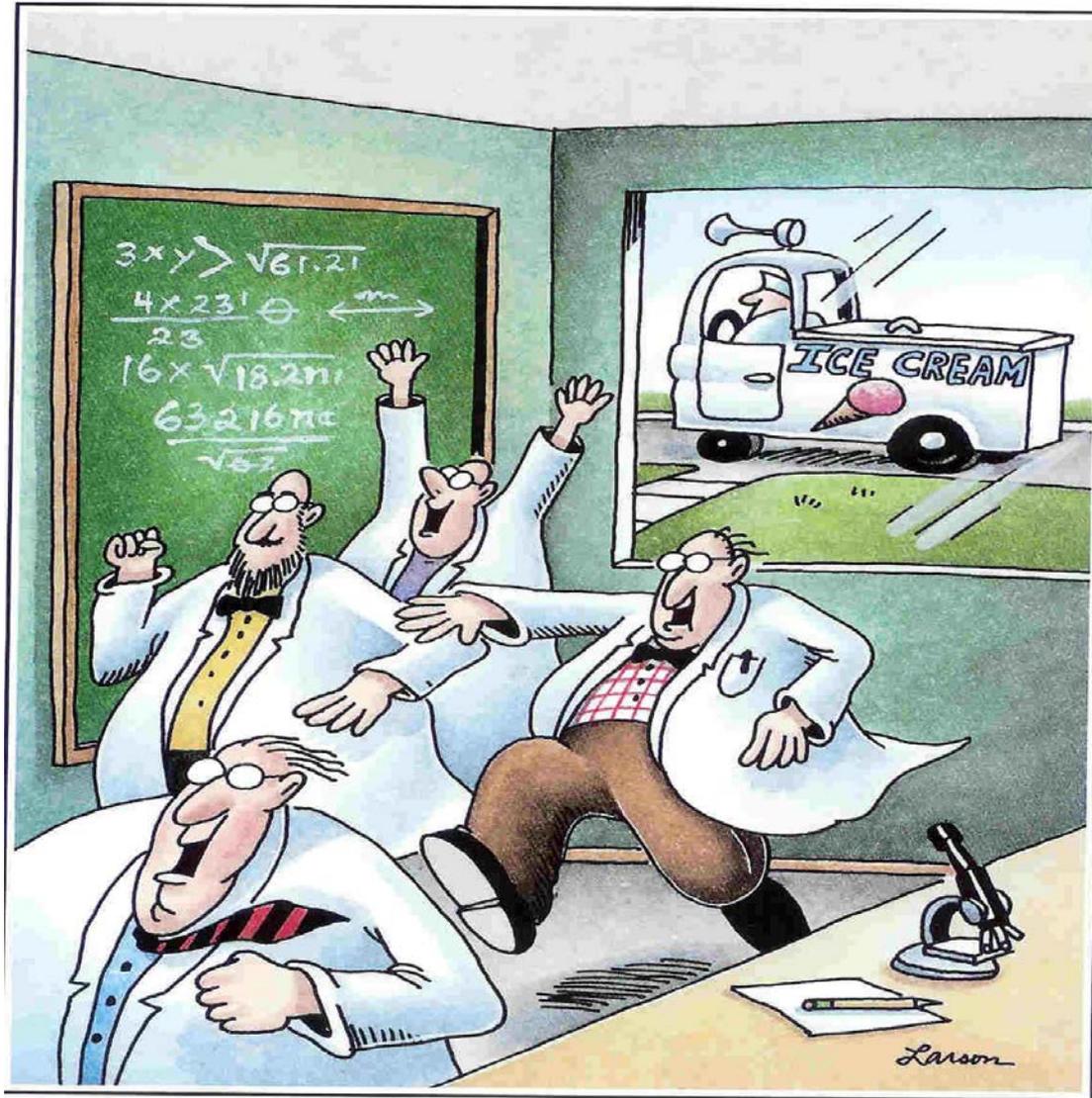
“It is not necessary to change... Survival is not mandatory”

- Edward Deming

- Speaking to a group of Detroit automaker executives 1970s

(there will likely be no “Pediatric” bailout)





So... Thank You!!

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