Advanced Coding and Billing Techniques for Pediatrics

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About the Presenter

- Master's Degree in Healthcare Business Leadership (MHBL)
- Fellow in the American College of Medical Practice Executives (FACMPE)
- Certified Professional Coder in the American Academy of Professional Coders (CPC)
- Manager of External Audits for Providence Health Plans in Beaverton, OR
- 19 Years Healthcare Experience
- 12 Years of Management Experience
- National Speaker on Management, Coding & Compliance Topics
Agenda

- Complex Medical Decision Making
- Pre-natal consulting
- High Risk newborn
- Preventive services
- Immunizations
- Pediatric Surgery

Medical Decision Making

- Prevalence of EMR templated documents
- History and Exam look similar
- MDM complex due to number of variables
- Level of visit primarily determined by:
  - Medical necessity
  - Number of diagnoses or management options
  - Amount and/or complexity of data
  - Risk of Complications and/or Morbidity and Mortality
Possible Diagnoses and/or Management Options

- Do you have high level?
  - Undiagnosed problem
  - Unresponsive to treatment
  - Number of problems/conditions addressed
  - One problem many management options
  - Risk of morbidity is moderate or high
  - Need for advice from others
  - Need for reviewing/ordering many tests or medical records

Possible Amount/Complexity of Data Ordered/Reviewed

- Do you have high level?
  - Combination of data tests required
  - Review/summarization of medical records
  - Results discussed with other provider
  - Order/review complex diagnostic tests
  - Poor historian/ no history available
  - Problems/ complaints vague
  - Obtaining advice from others
Possible Complications, Morbidity and/or Mortality

- Do you have high level?
  - Use Risk Table
  - Poor patient compliance
  - Uncertain prognosis
  - Probability of functional impairment
  - Need for invasive procedure
  - Need for prescription management
  - Need for IV therapy
  - Need for intensive or critical care
  - Surgical risk factors present

Determining Medical Decision Making

<table>
<thead>
<tr>
<th>TYPE OF DECISION MAKING</th>
<th>NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS</th>
<th>AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED</th>
<th>RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

Two of the three elements must either be met or exceeded.
Choosing Level of MDM

- There are no “official” defined parameters for the number of diagnoses required for each level of MDM.
- Using the nature of the presenting problem in association with the presenting problems in CMS Table of Risk can provide guidance.
  - Stable asthma – Low
  - Uncertain cause abdominal pain – Moderate
  - Severe Respiratory Distress - High

Pre-Natal Visit

- Provider documents a medical history
  - Background information about mom’s health
- A complete family history
  - Health of the parents, their children, their brothers, sisters, parents, and grandparents
- Documented statement:
  - “I spent 45 minutes with parents describing fetal and maternal risks for a mother with insulin-dependent diabetes, reviewed risks for infection, poor glucose control, and operative delivery; reviewed fetal anomaly risk including macrosomia, hypoglycemia and respiratory problems.”
- Code 99403 Preventative counseling 45 minutes
Preventative Counseling

- 99401-99404 discussion of risk reduction intervention
- No patient present
- No established symptoms or illness
- Pre-natal discussion of risks to fetus due to a family history of heritable disease
  - Prematurity
  - In Vitro fertilization
  - Congenital disorders

Attending the Delivery

- OB/GYN calls your provider to the delivery room for a possibly difficult delivery because baby’s mom is ill. Your provider documents:
  - The request for attendance
  - The provider’s immediate interventions
  - Discussion with parents
Attendance at delivery

- Physician attends delivery at request of delivering physician
  - Initial drying
  - Stimulation
  - Suctioning
  - Blow-by oxygen
  - CPAP
  - Assigning Apgars
  - Discussion of care with parents
- 99464
- May be reported with:
  - 99460 normal newborn
  - 99221-99223 sick newborn
  - 99477 initial intensive care
  - 99468 critical care
  - CPAP

Performing Antepartum Visits

- Mom undergoes a repeat cesarean section of a healthy full term 8lb. infant. Your physician examines the baby the next morning
  - He reviews the records
  - Examines the infant, and speaks to the parents
  - Provider sees them three days in the hospital
  - Provider performs circumcision on day 2
  - How do we code this?
Newborn Coding

Answer:

Day 1
99460
initial service
ICD V30.00

Day 2
99462-25
Subsequent hospital care, ICD V30.00 & 54150 circumcision, ICD V50.2

Day 3
99238 for discharge
ICD V30.00

Newborn Care

1. Normal Newborn visit, initial service
2. Normal Newborn visit, day 2
3. Discharge, normal newborn day 3

Normal Newborn evaluated & discharged same day

1. 99460-99461
2. 99462
3. 99238-99239

99463
Attendance at Delivery and Resuscitation

- Your physician is requested to attend delivery. Baby is resuscitated with positive pressure ventilation, intubated, and given surfactant. The baby is sent to NICU and your MD performs a complete history and physical exam, places infant on ventilator and inserts an umbilical artery catheter.

Coding the Example

- 99465 Delivery/ birthing room resuscitation
- 99468 Initial neonatal critical care
- Add procedures were performed as part of resuscitation
  - 31500 Endotracheal intubation
  - 93610 Surfactant administration
  - Might require modifier -59
Standby Services/Resuscitation

1. Physician standby requested (cannot attend to any other patients and must be immediately available)
   - 99360 (choose appropriate 30 min units): If less than 30 minutes cannot be billed

2. Newborn resuscitation (bag-and-mask, bag-to-endotracheal tube, with or without CPAP, cardiac compressions)
   - 99465 (other life support procedures may be coded separately)

Pediatric Critical Care and Intensive Care

- 99477
- 99478
- 99479
- 99480

Intensive Care Services

Global Critical Care
- 99468
- 99469
- 99471
- 99472
- 99475
- 99476

Hourly Critical Care
- 99291
- 99292
Patient’s Turn for the Worse

- On day 1 of the hospital stay infant starts out normal then later begins to show signs of persistent hypothermia. Your provider documents;
  - Intensive observation
  - Frequent interventions
  - Continual monitoring
- Code 99460 normal newborn service, ICD V30.00 and 99477 with modifier -25, ICD 780.65

Initial Care Complex Coding

- Neonate fine after birth later becomes jaundiced with bilirubin of 19
  - One physician for both services 99460-25 & 99231-99233
  - Two separate physicians = MD1 99460 MD2 99221-99223

- Neonate fine after birth later becomes lethargic with sinus tachycardia
  - One physician for both services 99460-25 & 99477
  - Two separate physicians = MD1 99460 MD2 99477

DOCUMENTATION MUST SUPPORT SERVICES OF ALL PROVIDERS
Initial Neonate Intensive Care

- 99477 Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires observation, frequent interventions, and other intensive care services
  - Day of admission or day of re-admission
  - Less than or equal to 28 days
  - Weight not a factor
  - Neonate who requires intensive care but does not qualify for critical care (requires frequent observation)

CPT® 99477

- For the initiation of inpatient care of the normal newborn report 99460
- For initiation of the care of the critically ill neonate use 99468
- For initiation of inpatient hospital care for the neonate not requiring intensive observation, frequent interventions, or other intensive care services, use 99221-99223
Subsequent Intensive Care

- **99478 Subsequent intensive care**, per day, recovering very low birth weight infant
  - Present body weight less than 1500 grams
- **99479 Subsequent intensive care**, per day, recovering low birth weight infant
  - Present body weight of 1500-2500 grams
- **99480 Subsequent intensive care**, per day, recovering infant
  - Present body weight of 2501-5000 grams

CPT 99478-99480

- VLBW/LBW or not critically ill, but continue to require any of the following:
  - Cerebral Palsy monitoring, and/or
  - Vital sign monitoring, and/or
  - Heat maintenance, and/or
  - Enteral /parenteral nutritional adjustments, and/or
  - Observation by the healthcare team under the direct supervision of a physician
  - Once a day by one physician (per diem code)
Critical Care Coordination

- Infant has been home for a few weeks and mother notices he’s having trouble breathing. Patient returns to the ED at three weeks old with respiratory distress.
- The ED physician provides an hour of critical care and patient is admitted to the PICU on the same day by the pediatrician.
  - ED physician = 99291 Critical Care first 30-74 min.
  - Pediatrician = 99468 Initial Inpatient neonatal critical care, per day for neonate 28 days or less

Outpatient to Inpatient Cross Over

- Critical care in the ED of patient five years or younger (99291-99292) that results in an inpatient admission by the same provider are reported with neonatal or pediatric critical care codes (99468-99472) because these codes are per day, and cannot be billed more than once per day
Definition of Critical Care

- Requires high complexity decision making to assess, manipulate, support vital system function to prevent deterioration
- Both the illness or injury and treatment meet critical care requirements
- Typically requires interpretation of multiple physiological parameters
- May be provided on multiple days as long as patient remains critically ill

Critical Care

Illness or injury acutely impairs one or more vital organs

High probability of imminent or life threatening deterioration of condition

Direct Delivery by Physician

Services Included in Critical Care

- **Bundled or Global Services:**
  - Vent management
  - CPAP
  - Surfactant administration
  - Transfusion of blood components
  - Invasive or noninvasive electronic monitoring of vital signs
  - Bedside PFTs
  - Blood gases
  - Oxygen saturation
  - All services normally bundled into Critical Care codes 99291-99292

- Venous and arterial catheters
- Vascular access procedures
- Vascular punctures
- Oral or nasogastric tube placement
- Endotracheal intubation
- Lumbar puncture
- Suprapubic bladder aspiration
- Bladder catheterization
Critical Care 99291-99292

- Ambulatory Setting (e.g. ED or office) for patient of any age
- Inpatient Setting for patient 72 months of age or greater
- Inpatient Setting, Critical care to neonate by 2nd physician of different specialty, any age
- Transport Setting, Physician in transport of child greater than to 24 months

Inpatient Neonatal Critical Care

- 99468 Initial
- 99469 Subsequent
- Per diem
- May be reported with:
  - Delivery room attendance (when requested by attending)
  - Delivery room resuscitation
  - Less than or equal to 28 days of age
- The initial day neonatal critical care code (99468) can be used in addition to 99464 (physician is present for the delivery) or 99465 (resuscitation) as appropriate
- Other procedures performed as a necessary part of the resuscitation
  - (eg, endotracheal intubation [31500])
Transition to Pediatric Critical Care

- Patient is 4 yrs. old and is not responding to treatment, he is moderately ill with respiratory distress. X-Ray shows right lower lung infiltrate with flattened diaphragm. Child is transferred to PICU and the physician begins critical care services.
- Codes 99475 critical care, ICD 486 (pneumonia)

Inpatient Pediatric Critical Care

- 99471 Initial
- 99472 Subsequent
- Per diem
- 29 days to 24 months old
- They represent care starting with the date of admission (99471, 99475) and subsequent day(s) (99472, 99476) the infant or child remains critical. These codes may be reported only by a single physician and only once per day, per patient in a given setting.
Inpatient Pediatric Critical Care

- 99475 Initial
- 99476 Subsequent
- Per diem
- 2 years to 71 months old
- If patient in PICU and crosses from 23 to 24 months, would begin PICU with 99471 but report subsequent with 99476
- Keep track of ages, or will receive denials

Well Child Check ICD-9-CM

- Did you know there are multiple well-care diagnosis codes?
  - V20.31 health supervision for newborn < 8 days
  - V20.32 health supervision for newborn 8-28 days old
  - V20.2 routine infant or child check (29 days - 17 years)
  - V70.0 general medical exam for patient over 17 years old
Commonly Missed Screening Services

- Per CPT® instructions; screening tests identified with CPT® codes are coded separately
- Hearing screening and assessment
  - 92551 screening test pure tone, air only
  - 92552 full pure tone audiometric assessment
  - 92568 Acoustic reflex testing
- Urinalysis
  - 81000-81003

Commonly Missed Screening Services

- Vision Screening and assessment
  - 99173 screening test of visual acuity, quantitative, bilateral (Snellen chart)
- Screening lab work
  - 36416 – Collection of capillary blood
    - PKU test
  - 36415 – Venipuncture
    - Access vein for blood draw
- Preparation of specimen blood or other
  - 99000 or Q0091 for pap smear prep
Hearing and Vision Screening ICD

- Common coding errors for routine hearing and vision screening
- As part of preventive screening
  - V20.2 – included in preventive service
- Screening due to reason (headache, difficulty hearing)?
  - V72.0 examination of eyes and vision
  - V72.19 other examination of ears and hearing
  - V72.11 hearing examination following failed screening

Pediatric Immunizations

Coding from both CPT code families

Vaccine Code + Administration Code = Correct Coding
Pediatric Vaccine Administration

90460 - 90461
- Up to 18 years of age, via any route of administration
- With counseling, Per vaccine/toxoid component

90471-90472
- Any age, percutaneous, subcutaneous, IM, jet
- Per vaccine (single or combination vaccine/toxoid)

90473 - 90474
- Any age, intranasal or oral route
- Per vaccine (single or combination vaccine/toxoid)

HPV With Counseling Example

- A patient receives human papillomavirus vaccine. Ordering physician discusses the risks of the vaccine and the disease it prevents. Parent given VIS and signs consent form. The nurse prepares, administers, and documents vaccine.
  - CPT® 90460 initial vaccine component admin. & 90649 HPV vaccine
  - ICD V04.89 Need for inoculation against other viral disease
Multiple Vaccines With Counseling

A patient receives the diphtheria, tetanus, pertussis, *Haemophilus influenzae* type b, inactivated polio (DTaP-Hib-IPV) combination vaccine; rotavirus vaccine; and pneumococcal conjugate vaccine from her physician. Physician discusses risks and benefits of each component vaccine. Parent given VIS, signs consent. Nurse prepares, provides, and documents each vaccine.

Coding the Multiple Vaccines Example

<table>
<thead>
<tr>
<th>CPT</th>
<th>ICD</th>
</tr>
</thead>
<tbody>
<tr>
<td>90698 DTaP-Hib-Polio</td>
<td>V20.2 routine check</td>
</tr>
<tr>
<td>90460 First component admin</td>
<td>V06.3 DTP &amp; polio</td>
</tr>
<tr>
<td>90461 x4 for addl admin</td>
<td>V03.81 Hib</td>
</tr>
<tr>
<td>90480 rotavirus</td>
<td>V20.2 routine check</td>
</tr>
<tr>
<td>90460 First component admin</td>
<td>V04.89 rotavirus</td>
</tr>
<tr>
<td>90669 pneumococcal</td>
<td>V20.2 routine check</td>
</tr>
<tr>
<td>90460 First component admin</td>
<td>V03.82 pneumococcal</td>
</tr>
</tbody>
</table>
Vaccine Administration Billing

- Reimbursement troubles? Use white paper to educate payers on true costs of vaccine administration.

- VFC coding state specific
  - Vaccines for Children federal program
  - Bill just vaccine/Follow state guidelines

Link to Complete 2010-2011 AAP Vaccine Coding Table

- **Vaccine Coding Table**
  - Includes CPT and ICD-9-CM codes for 40 Vaccines
  - List by Manufacturer & Brand
Vaccines CPT “Early Release”

- **Vaccine Product Codes “Early Release” on the Website**
  - Published in CPT® each October- Active January 1st
  - Appear Twice a Year on the AMA website “Early Release”
  - January 1st and July 1st
    - Codes Become “Active” for use 6 months after appearing

Pediatric Surgery

- Patient admitted to the hospital for placement of a central venous access and repair of right and left inguinal hernia. The first venous access fails so the surgeon has to place a second one later.
  - 49505-50 – Bilateral hernia repair
  - 36555 first catheter
  - 36555-76 redo of catheter on same day
Surgery/Procedure Modifiers

- **-22 Increased Procedural Service**
  - Greater than typical work during a procedure
  - Requires clear documentation - payer specific

- **-50 Bilateral Procedure**
  - Right and left arm fracture repair 25500-50

- **-51 Multiple Procedures – payer specific**
  - Repair of simple wound of arm and wart removal toe 12001, 17110-51

Surgery/Procedure Modifiers Continued

- **-52 Reduced/-53 Discontinued Services**
  - Not able to complete circumcision
    - 54150-52 (danger to patient 54150-53)

- **-58 Staged or related procedure during global**
  - Planned at the time of the initial surgery – Closure of perineal urethrostomy 5 weeks post hypospadias repair, 53520-58

- **-59 Distinct Procedural Service**
  - Nebulizer and inhaler teaching same day
    - 94640, 94664-59
Surgery/Procedure Modifiers Continued

-63 Procedure performed on infants weighing less than 4 kg.
  - Append modifier to any procedure on an infant less than 4kg that does not specify infant in CPT description
-76 Repeat procedure or service by the same physician
  - Nebulizer treatment repeated 94640, 94640-76
-78 Unplanned return to the OR by same MD for related procedure
  - Treat abdominal hemorrhage post surgery, 35840-78

Return During Global

- Shortly after recuperating from his recent surgery, patient was seen again in the office for an upper respiratory infection. Pediatrician documents an expanded problem focused visit.
  - Visit during global normally would not be charged, however this is an unrelated issue from surgery
- Codes 99213 with modifier -24, ICD 465.9 (Acute URI)
E/M Modifiers

-24 Unrelated E/M by the same MD during post-op period
  - Seeing patient for ear infection 7 days after wound repair in office
-25 Significant, Separately Identifiable E/M by the same MD on the same day of the procedure or other service
  - Finding unknown significant illness or injury during routine preventive visit

E/M Modifiers Continued

-52 Reduced Services
  - You are unable to complete a visit as planned due to disruptive child behavior or family member behavior
-57 Decision for Surgery
  - Surgeon consults on a patient for abdominal pain. During visit determines urgent strangulated hernia repair necessary. Surgeon report 99241-99245-57 (consults may be payer specific) and 49507 for surgery
**Appeal Process**

- Identify incorrectly-processed claim by review EOB/EOP
- Contact payer identify proper procedure
- Generate new/corrected claim
- Write professional, clear letter
- Include authoritative source information
- Send to appropriate appeal address or fax number at payer

**Sample Appeal Language**

- Dear Insurance Claim Person
- I am writing this letter on behalf of your insured
- Name, ID#, Date of Service, Amount Billed
- Your original processing incorrectly denied this service for _________________.
- Based on CPT®, AAP, CMS guidelines it should have been processed ________________ (include copies of references when possible)
- We will expect to see this claim reprocessed for appropriate payment within the next two weeks, please contact us at __________
When appeals do not work

• If you’ve appealed the decision and have been rejected again, go through the carrier’s different levels of appeal
  – 1st level claims review
  – 2nd level nurse review
  – 3rd level medical director review
• If unsuccessful, attempt to get your issue to their medical director committee review
  – New technology, new drugs, review policy

What next?

• If your issue is not satisfactorily resolved with medical director level
  – Connect with contracting
  – Work with contract negotiation to have specific issue addressed at contract level
    • Overturn edits
    • Resolve underpayment of drugs/biologicals
    • Increase reimbursement of procedure or services with bundled services
    • Carve outs
Resources

- AAFP – www.aafp.org
- AAPC – www.aapc.com
- AAP Coding for Pediatrics book 2009 (14th edition)
- Medical Group Management Association - www.mgma.com

Questions and Answers

Email questions: lisa.jensen@providence.org

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