Pediatric Coding and Billing

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Evaluation and Management

Office
Hospital
Counseling
Well-child Care
Common Office Procedures
Vaccinations and Other Injections
Underutilized Codes - per AAP
Evaluation and Management Services

Same Documentation Guidelines as for adults

Limitations?

• Review of Systems on small child?

• Social History
  • School performance
  • Extracurricular activities
  • Marital status of parents/Living arrangements
The Basics of E&M

- Documentation Guidelines
  
  Two sets of guidelines established by CMS
  
  - 1995 Documentation Guidelines
  - 1997 Documentation Guidelines

  Providers may use whichever they choose.

  Auditors are instructed to audit under both sets of guidelines and allow the physician to use whichever benefits him/her.
History

• Ancillary staff may document Review of Systems and Past, Family, Social History

• Provider must personally document History of Present Illness

• Chief complaint may be inferred.

• May use patient-completed history form, but provider must date and initial form and refer to it in documentation.
Chief Complaint - History of Present Illness

- History of Present Illness expands on chief complaint

<table>
<thead>
<tr>
<th>Location</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity</td>
<td>Duration</td>
</tr>
<tr>
<td>Timing</td>
<td>Context</td>
</tr>
<tr>
<td>Modifying factors</td>
<td>Associated signs &amp; symptoms</td>
</tr>
</tbody>
</table>
History of Present Illness

In lieu of HPI elements, can list the status of three chronic conditions –

CMS clarified that this can also be applied to the 1995 Guidelines

How often will you use this in Pediatrics?
Review of Systems

• The history element that is most often lacking

• May indicate “All other systems negative” after documentation of related system – IF reviewed all

• But must list at least one system specifically

• “ROS – Negative” is insufficient documentation for complete Review of Systems
Review of Systems

- Constitutional
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/
  Lymphatic
- Allergic/Immunologic
Past, Family, Social History

Past – current medications; hospitalizations; surgeries; vaccinations

Family - hereditary diseases; health status of parents, siblings, children

Social – smoking, alcohol and drug use; marital status; living arrangements; level of education; employment history

Different considerations for Pediatrics?
Examination

- 1997 Guidelines
  - Bullets
- 1995 Guidelines
  - Body areas/Organ systems
    - 8 organ systems required for comprehensive examination
Medical Decision-Making

This is the documentation of the physician’s thought process

• Number of Diagnoses and Management Options
• Amount and Complexity of Data
• Risk
Contributory Components

- Nature of Presenting Problem
- Time
Nature of Presenting Problem

- How sick is this patient?
- Indicates medical necessity
- May be considered the “tie-breaker” when deciding between two levels of service.
- May not necessarily be reflected by the diagnosis code.
## Nature of Presenting Problem

<table>
<thead>
<tr>
<th>Nature of Presenting Problem</th>
<th>Level of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-limited or minor problem</strong></td>
<td>99201/99202/99212</td>
</tr>
<tr>
<td><strong>Two or more self-limited or minor problems</strong></td>
<td></td>
</tr>
<tr>
<td><strong>One stable chronic illness</strong></td>
<td>99203/99213</td>
</tr>
<tr>
<td><strong>Acute uncomplicated illness or injury</strong></td>
<td>99204/99214</td>
</tr>
<tr>
<td><strong>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</strong></td>
<td>99205/99215</td>
</tr>
<tr>
<td><strong>Two or more stable chronic illnesses</strong></td>
<td>99221/99231</td>
</tr>
<tr>
<td><strong>Undiagnosed new problem with uncertain prognosis</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Acute illness with systemic symptoms</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Acute complicated injury</strong></td>
<td>99222/99232</td>
</tr>
<tr>
<td><strong>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</strong></td>
<td>99223/99233</td>
</tr>
<tr>
<td><strong>Acute or chronic illness or injury that poses a threat to life or bodily function</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Abrupt change in neurologic status</strong></td>
<td></td>
</tr>
</tbody>
</table>
Counseling

Evaluation and Management codes may be assigned based on time if counseling and coordination of care exceed 50% of the time spent.

Per CPT, time is spent with the patient and/or family – so patient does not have to be present. (But be aware of any payer-specific requirements that the patient be present.)
Counseling Time

- Time must be documented as well as subjects discussed

Ex: “I spent 20 minutes of this 25 minute visit discussing treatment options for the patient’s new diagnosis of asthma.” - 99214

Ex: “I spent this entire 40-minute visit counseling with the parents regarding the patient’s behavior problems at school and the possible diagnosis of ADHD.” - 99215
<table>
<thead>
<tr>
<th>New Patient (must meet all 3)</th>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>chief complaint 1-3 HPI</td>
<td>chief complaint 1-3 HPI</td>
<td>chief complaint 4 or more HPI</td>
<td>chief complaint 4 or more HPI</td>
<td>chief complaint 4 or more HPI</td>
</tr>
<tr>
<td>Examination</td>
<td>1 system</td>
<td>2 - 7 systems</td>
<td>2 - 7 systems</td>
<td>8 or more systems</td>
<td>8 or more systems</td>
</tr>
<tr>
<td>Medical Decision-Making</td>
<td>(must meet 2 of 3) minimal diagnoses minimal/no data minimal risk</td>
<td>(must meet 2 of 3) minimal diagnoses minimal/no data minimal risk</td>
<td>(must meet 2 of 3) limited diagnoses limited data low risk</td>
<td>(must meet 2 of 3) multiple diagnoses moderate data moderate risk</td>
<td>(must meet 2 of 3) extensive diagnoses extensive data high risk</td>
</tr>
<tr>
<td>Time (only relevant if counseling &gt;= 50%)</td>
<td>10 minutes</td>
<td>20 minutes</td>
<td>30 minutes</td>
<td>45 minutes</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Established Patient (must meet 2 of 3)</td>
<td>99211</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
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<tr>
<td><strong>History</strong></td>
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<td>chief complaint</td>
<td>1-3 HPI</td>
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<td>1-3 HPI</td>
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<tr>
<td>1 ROS</td>
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<tr>
<td>pertinent PFSH</td>
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<tr>
<td>complete PFSH</td>
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<tr>
<td><strong>Examination</strong></td>
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<tr>
<td>1 system</td>
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<tr>
<td>2 - 7 systems</td>
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<td>2 - 7 systems</td>
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<td>8 or more systems</td>
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<tr>
<td><strong>Medical Decision-Making</strong></td>
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<tr>
<td>(must meet 2 of 3) minimal diagnoses</td>
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<tr>
<td>minimal/no data</td>
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<td>minimal risk</td>
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<tr>
<td>limited diagnoses</td>
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<td>limited data</td>
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<td>low risk</td>
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<td>multiple diagnoses</td>
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<td>moderate data</td>
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<td>moderate risk</td>
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<td>extensive diagnoses</td>
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<td>extensive data</td>
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<td>high risk</td>
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<td>(must meet 2 of 3)</td>
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<td>extensive diagnoses</td>
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<tr>
<td>extensive data</td>
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<tr>
<td>high risk</td>
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<tr>
<td><strong>Time</strong> (only relevant if counseling &gt;= 50%)</td>
<td>5 minutes</td>
<td>10 minutes</td>
<td>15 minutes</td>
<td>25 minutes</td>
<td>40 minutes</td>
</tr>
</tbody>
</table>
99213 or 99214?

- Otherwise healthy 7y.o. child comes in with cough, congestion, pain in ears – diagnosis is URI and otitis media. Prescription is given for Amoxicillin. Documentation:
  - Detailed history (4 HPI, 2+ systems reviewed, NKDA)
  - Detailed examination (vitals, eyes, ENMT, heart, lungs)
  - Moderate complexity (new problem, no addl workup, prescription drug management)
- Nature of Presenting Problem: Acute, uncomplicated illness or injury
99213 or 99214?

- Child is seen one week later - presents with rash but no difficulty breathing or other systemic symptoms. Diagnosis is allergic reaction to Amoxicillin
  - Detailed history
  - Detailed examination
  - Moderate complexity (New problem? – illness with mild exacerbation, progression, or side effects of treatment)
- Nature of presenting problem ???
99213 or 99214?

- 14yo patient previously diagnosed with asthma presents with acute exacerbation
  - Detailed history
  - Detailed examination
  - Complexity? – established problem worsening, prescription drug management
  - What if diagnosis is URI in patient with asthma?
- Nature of presenting problem – chronic illness with mild exacerbation – supports 99214

Chronic illness with severe exacerbation - 99215
Office Visit with Procedures

• Modifier 25 - Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of Procedure or Other Service

• Beyond the usual preop and postop care

• Different diagnosis is not required

• Be sure to check global periods on minor procedures
Modifier 25

“In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles.”

NCCI Manual
Hospital Care

Unless critical care for patients under the age of five, use the same codes and guidelines as for adults.

For critical care services under the age of five, the codes are per day and inpatient only –

Age 1-28 days – 99468 initial/99469 subs
Age 29 days – 24 months –
    99471 initial /99472 subs
Age 2 – 5 years – 99475 initial/99476 subs
Neonatal Intensive Care

Initial Neonatal Intensive Care

99477 – initial hospital care, per day, for E&M of neonate, 28 days or less, who requires intensive observation, frequent interventions, and other intensive care services

Progression –

well-baby – 99460
sick baby – 99221-99223
intensive – 99477
critical – 99295
Hospital Admission

- No office visit is to be charged on the date a patient is admitted to the hospital.

- The CPT codes for hospital admission indicate “Initial hospital care, per day” – all services provided that day are rolled into that one code.

- What if patient is admitted from the office but not seen in the hospital on that day?
Hospital Admissions

Billed the date of visit

• Three levels
  • 99221
  • 99222
  • 99223
Subsequent Visits

- Three levels
  - 99231
  - 99232
  - 99233
- It is expected that the level of service will decrease during the hospital stay
- Diagnosis Coding – code for what you saw the patient for that day!
- Issues with Concurrent Care
99231 “Usually, the patient is stable, recovering or improving.”

99232 “…the patient is responding inadequately to therapy or has developed a minor complication.”

99233 “Usually, the patient is unstable or has developed a significant complication or a significant new problem.”
<table>
<thead>
<tr>
<th></th>
<th>Initial Inpatient Care (Hospital Admit H&amp;P)</th>
<th>Subsequent Care (Daily Visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99221</td>
<td>99222</td>
</tr>
<tr>
<td></td>
<td>3 of 3</td>
<td>3 of 3</td>
</tr>
<tr>
<td>History</td>
<td>chief complaint 4 or more HPI</td>
<td>chief complaint 4 or more HPI</td>
</tr>
<tr>
<td></td>
<td>2 - 9 ROS</td>
<td>10 or more ROS</td>
</tr>
<tr>
<td></td>
<td>1 element PFSH</td>
<td>complete PFSH</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examination</td>
<td>2 - 7 systems/areas</td>
<td>8 or more systems</td>
</tr>
<tr>
<td></td>
<td>(in detail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(must meet 2 of 3)</td>
<td>(must meet 2 of 3)</td>
</tr>
<tr>
<td></td>
<td>minimal diagnoses</td>
<td>multiple diagnoses</td>
</tr>
<tr>
<td></td>
<td>minimal/no data</td>
<td>moderate data</td>
</tr>
<tr>
<td></td>
<td>minimal risk</td>
<td>moderate risk</td>
</tr>
<tr>
<td>Medical Decision-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Making</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td>30 minutes</td>
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</tbody>
</table>
Hospital Discharge

Coded based on time spent in discharge activities:

- 99238 - 30 minutes or less

- 99239 - More than 30 minutes

Time must be documented or default to 99238.
Normal Newborn Care

• 99460 – Initial, hospital or birthing center
• 99461 – Initial, other location
• 99462 – Subsequent hospital care
• 99463 – Initial, hospital or birthing center, admit/discharge same day

Clarification that attendance at delivery, 99464, or newborn resuscitation, 99465, can be billed in addition to initial care codes same day – 99460, 99468, 99477
Coding for Preventive Medicine

- Visits
  - New vs. Established Patient
  - Based on patient’s age
  - Guidelines established by specialty societies
- Counseling
  - New or Established Patient
  - Time-Based
Preventive Medicine Codes

99381/99391 – under 1 year
99382/99392 – 1- 4 years
99383/99393 – 5 – 11 years
99384/99394 – 12 - 17 years

Comprehensive nature of the Preventive Medicine services reflects an age and gender appropriate history/exam and is NOT synonymous with the comprehensive examination in other E&M codes.
“If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine service, and if the problem is significant enough to require additional work to perform the key components of a problem-oriented E&M service, the appropriate Office/Outpatient code should also be reported…Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable E&M service was provided….”
Preventive Medicine Counseling

• For patients who do not have symptoms or established illnesses for which the counseling is provided

• Time-based

• May be provided/billed at same visit as E&M

• Some payors may ignore CPT guidelines and ask that you bill this with visit code in order to provide a separately covered service
## Preventive Medicine Counseling

<table>
<thead>
<tr>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>99401 – 15 minutes</td>
<td>99411 – 30 minutes</td>
</tr>
<tr>
<td>99402 – 30 minutes</td>
<td>99412 – 60 minutes</td>
</tr>
<tr>
<td>99403 – 45 minutes</td>
<td></td>
</tr>
<tr>
<td>99404 – 60 minutes</td>
<td></td>
</tr>
</tbody>
</table>
Early Periodic Screening Detection and Treatment

- Unclothed physical exam
  - Vitals, including BP after age 3; BMI
- Comprehensive family/medical history
- Immunization status
- TB skin test
- Developmental assessment
- Nutritional status screening
- Health education/anticipatory guidance

Billed with preventive medicine code with mod –EP

(Billing requirements may vary per each state Medicaid)
Interperiodic EPSDT

- Visits to follow up problems discovered during EPSDT

- Billed with regular office visit codes with modifier –EP (billing requirement)

- Diagnosis code reflects the problem being followed
Sports Physicals

• Per the AMA, coded as preventive medicine IF comprehensive history and examination performed; otherwise, bill with appropriate level of office/outpatient code.

• Recommendation: Use dummy code to track and collect -
Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Blood Pressure screening for children
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age 3, and surveillance throughout childhood
• **Dyslipidemia** screening for children at higher risk of lipid disorders

• **Fluoride Chemoprevention** supplements for children without fluoride in their water source

• **Gonorrhea** preventive medication for the eyes of all newborns

• **Hearing** screening for all newborns

• **Height, Weight and Body Mass Index** measurements for children

• **Hematocrit or Hemoglobin** screening for children
• **Hemoglobinopathies** or sickle cell screening for newborns
• **HIV** screening for adolescents at higher risk
• **Iron** supplements for children ages 6 to 12 months at risk for anemia
• **Lead** screening for children at risk of exposure
• **Medical History** for all children throughout development
• **Obesity** screening and counseling
• **Oral Health** risk assessment for young children
• **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
• **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk

• **Tuberculin** testing for children at higher risk of tuberculosis

• **Vision** screening for all children

http://www.healthcare.gov/law/about/provisions/services/lists.html
## Example – Preventive Coverage

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD9 Code – Prior to 10/1/15</th>
<th>ICD10 Code – Effective 10/1/15</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression, Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ages 12 years and older</td>
<td>99401 with diagnosis V79.0</td>
<td>99401 with diagnosis Z13.69</td>
<td></td>
</tr>
<tr>
<td>• One each calendar year</td>
<td>1/1/12 add G0444</td>
<td>1/1/12 add G0444</td>
<td></td>
</tr>
<tr>
<td>• Ages 11 years and older</td>
<td>6/30/12 cancel 99401</td>
<td>6/30/12 cancel 99401</td>
<td></td>
</tr>
<tr>
<td>Developmental Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ages 9-30 months</td>
<td>96110 with routine diagnosis</td>
<td>96110 with routine diagnosis</td>
<td></td>
</tr>
<tr>
<td>• Four services during age range</td>
<td>1/1/12 add G0451</td>
<td>1/1/12 add G0451</td>
<td></td>
</tr>
<tr>
<td>• Ages 9-30 months</td>
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<tr>
<td>• Five services during age range</td>
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<tr>
<td>Developmental Surveillance for Children</td>
<td>Included as part of an office visit</td>
<td>Included as part of an office visit</td>
<td></td>
</tr>
<tr>
<td>Developmental/Behavioral Assessment – Alcohol and Drug</td>
<td>G0396, H0001, or 96408 with diagnosis V69.8 or V69.9</td>
<td>G0396, H0001, or 99408 with diagnosis Z72.0, Z72.86, Z72.9, or Z73.9</td>
<td></td>
</tr>
<tr>
<td>• Ages 11-21 years</td>
<td>1/1/12 add G0442, G0443</td>
<td>1/1/12 add G0442, G0443</td>
<td></td>
</tr>
<tr>
<td>• One each calendar year</td>
<td>6/30/12 cancel 99408</td>
<td>6/30/12 cancel 99408</td>
<td></td>
</tr>
<tr>
<td>Dyslipidemia Screening</td>
<td>80061 with diagnosis V77.91</td>
<td>80061 with diagnosis Z13.220</td>
<td></td>
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<tr>
<td>• Ages 2 - 10 years: Once every 2 calendar years</td>
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<tr>
<td>• Ages 11 - 17 years: One each calendar year</td>
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<tr>
<td>• Ages 18 – 21 years: Once during age range</td>
<td></td>
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</tbody>
</table>
Common Office Procedures

- Laceration Repairs
- Closed Treatment of Fractures
- Removal of Foreign Body
- Nebulizer Treatments
Laceration Repairs

Coded by length, site, and type of repair – common sites are added together – use one code

Use of tissue adhesives (Dermabond) – coded as simple repair – cannot code separately for supply of adhesive.

Closure with steri-strips coded as E&M

Local anesthesia included in repair code
Closed Treatment of Fractures and Dislocations

Clavicle fx – 23500 w/o manipulation
   23505 w/ manipulation

AC dislocation – 23540 w/o manipulation
   23545 w/ manipulation

Nursemaid elbow – 24640

Metacarpal – 26600 without manipulation (each)
   26605 with manipulation (each)
Fractures and Dislocations, cont

MCP dislocation – 26700

Phalangeal shaft fx – 26720 w/o manipulation
  (finger)  26725 w/ manipulation

Distal phalangeal fx – 26750 w/o manipulation
  (finger)  26755 w/ manipulation

Great toe fx – 28490 w/o manipulation
  28495 w/ manipulation
Fractures and Dislocations, cont
Phalanx/phalanges fx – 28510 w/o manipulation (other than great toe)
   28515 w/ manipulation
MTP dislocation – 28630
IP dislocation – 28660
Global Fracture Care

Restorative vs. Supportive

Manipulative

Non-Manipulative

• Exclude complications
• Manage pain
• Educate patient and parents
• Follow-up as needed

Cannot code initial cast/splint application with global fracture care – can code replacement casts
Fracture Care or E&Ms

• Can code E&M with initial fracture care (if modifier 25 requirements met)
• Two choices for coding non-manipulative fractures – either is correct
  • Fracture care – 90 day global – cannot code for followup visits
  • E&Ms for every visit, cast/splint application
• Can always code for xrays and casting supplies
Removal of Foreign Body

Ear – external auditory canal – 69200
   (old ventilating tube not considered FB)
Eye – conjunctival superficial – 65205
   conjunctival embedded – 65210
Removal of Foreign Body

Skin – incision and removal – subcu –

simple – 10120

complicated - 10121

No incision? – E&M service
Nebulizer Treatment

94640

- Code includes supply – bill medication separately
- May bill for multiple treatments on the same day with modifier –76 on subsequent treatments.
Vaccinations and Other Injections

Administration coded separately from vaccine or medication

- 96372 – therapeutic injection, subcu or IM
Vaccine Administration

Codes for administration with counseling – for patients age 18 and under

- 90460 – first vaccine/toxoid component
- 90461 – each additional vaccine/toxoid component

Counseling must be performed by physician and must be documented for each component

All routes of administration

Use 90460 for each vaccine administered
Use 90471, 90472 for each injection if no counseling
Diagnosis code Z23 for all immunizations
2-month old infant receives the following immunizations according to schedule

DTaP – 90460, 90461, 90461, 90700

Rotavirus – 90460, 90681

Hepatitis B and HiB – 90460, 90461, 90748

Poliovirus – 90460, 90713

Pneumococcal vaccine – 90460, 90670
Top Ten Underutilized Codes

According to the American Academy of Pediatrics

- 99214 and 99215
- Office Consultation Codes
- Separate E&M with preventive medicine
- E&M with procedure – modifier –25
- 99058 – office services provided on an emergency basis
- 99050/99052 – services after posted office hours or between 10:00pm and 8:00am
Underutilized Codes

• 99054 – services provided on Sundays and holidays
• Nursemaid’s elbow – 24640
• Care Plan Oversight – home health care – 99374/99375
• Case Management Codes
  • Team Conferences – 99366-99367
  • Telephone Calls – 99441-99443
Documentation Issues

• Documentation must clearly indicate the reason for the visit and any coexisting conditions that affect treatment and care.

• Documentation for each visit must stand alone.

• Diagnosis indicated on encounter form/charge ticket/superbill but not documented in medical record

• If practice uses a problem list, it must be updated at each visit – and referenced in the documentation for the date of service.

• Each progress note should be signed with credentials.
Examples

“BOMAMOX”

“Warts. Done.”
ICD-10-CM Concerns for Pediatrics
ADHD in ICD-10-CM

F90.0 – predominantly inattentive type

F90.1 – predominantly hyperactive type

F90.2 – combined type

F90.8 – other type

Code separately for anxiety, mood disorders, developmental disorders
Injuries

Seventh Character - 2016 Guideline Change –

7\textsuperscript{th} character for injuries –

“Our patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7\textsuperscript{th} character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.”

Underdosing

Underdosing may be intentional or not intentional

- Z91.120 – intentional underdosing due to financial hardship
- Z91.128 – intentional underdosing due to other reason
- Z91.130 – unintentional underdosing due to age-related debility
- Z91.138 – unintentional underdosing due to other reason
- Z91.14 – underdosing unspecified
Child returns following treatment for bilateral otitis media. She seemed to feel better for a few days but now pulling at ears again. Mom admits to stopping antibiotic on day 3 because the child was “so much better.”

- **H65.93** – Unspecified nonsuppurative otitis media, bilateral
- **T36.0X6A** – Underdosing of penicillins, initial encounter
- **Z91.128** – intentional underdosing due to other reason
Routine Examinations

“An examination with abnormal findings refers to a condition/diagnosis that is newly identified or a change in severity of a chronic condition (such as uncontrolled hypertension, or an acute exacerbation of chronic obstructive pulmonary disease) during a routine physical examination.”
Questions?
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