KNOW THE BREAD AND BUTTER OF PEDIATRICS

By

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Overview

- New, revised CPT codes for Pediatrics

- Evaluation and Management Review

- Procedure Coding and Documentation

- ICD-10 Updates and review

New Assessment Code for Cognitive Impairment

- **NEW 99483: assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home.**
  - *This service is provided when a comprehensive evaluation of a new or existing patient who exhibits signs and/or symptoms of cognitive impairment, is required to establish or confirm a diagnosis, etiology and severity for the condition.*
  - *MANY requirements!*
    - Cognitive-focused evaluation including a pertinent history and examination.
    - MDM of moderate or high complexity
    - Functional assessment (basic and instrumental activities of daily living), including decision-making capacity.
    - Use of standardized instruments for staging of dementia (functional assessment staging test {FAST}. Clinical dementia rating {CDR}
    - Medication reconciliation and review for high risk medications.
    - Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instruments.
    - Evaluation of safety (home), including motor vehicle operation.
    - Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks.
    - Development, updating or revision, of an Advanced care plan
    - Creation of a written care plan
  - *Total Time is typically 50 minutes.*

Psychiatric Collaborative Care Management Services

- **99492**: Initial psychiatric collaborative care management, first 70 min. in the first calendar month of behavioral health care manager (requires a masters/doctoral level education or specialized training in behavioral health) activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with requirements
    - *Outreach to and engagement in treatment of a patient directed by the treating physician or other QHP.*
    - *Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan.*
    - *Review with the psychiatric consultant with modifications of the plan if recommended*
    - *Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant;*
    - *Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.*
- **99493**: Subsequent psychiatric collaborative care management, first 60 min. in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP
    - *Tracking patient follow up and progress with registry*
    - *Participation in weekly caseload consultation with the psychiatric consultant*
    - *Basically same criteria as initial-see CPT for further information*
- **99494**: Initial or subsequent psychiatric CCM, each 30 minutes.

General Behavioral Health Integration Care Management

- 99484: Care management services for behavioral health conditions at least **20 minutes of clinical staff time**, directed by a physician or other QHP, per calendar month, with the following requirements:
  - *Initial assessment or follow up monitoring including the use of applicable validated rating scales.*
  - *Behavioral health care planning in relation to behavioral/psychiatric health problems*
  - *Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation*
  - *Continuity of care with a designated member of the care team.*
- The reporting professional must be able to perform the E/M services of an initiating visit.
- Cannot be used at same time as the psychiatric collaborative care management.
- BHC integration clinical staff DO NOT need special qualifications that would permit them to report a service separately

Medicine Section

- Vaccines:
  - ***90567****: (not FDA approved): Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use*
  - ***90750:*** *(not FDA approved): Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for IM use.*
  - ***90682****: Influenza virus vaccine quadrivalent (RiV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for IM use.*
  - ***90756****: Influenza virus vaccine, quadrivalent (ccllV4), derived from cell cultures, subunit, antibiotic free, .5ml. dosage for IM use.*
  - *90621: revised Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp),* ***"2 or"*** *3 dose schedule for IM use.*
  - *90651: revised- HPV vaccine, added* ***"2 or"*** *to the 3 dose schedule*

Pulmonology Changes

- **94617: New**: Exercise test for bronchospasm, including pre and post spirometry, electrocardiographic recording and pulse oximetry

- **94618: New: deleted 94620** Pulmonary stress testing (6 minute walk test), including measurement of heart rate, oximetry, and oxygen titration (when performed).

EVALUATION AND MANAGEMENT REVIEW
OH NO!   NOT AGAIN!!!

Pediatrics Down Codes!

- Typical code used is 99203 new patient code or 99213.

- Typical history is detailed history, expanded problem focused exam so medical decision making will determine level of care

- Most providers "give up" at the end of the visit in their thinking process-IE: "seems simple to me, must be a 99213"!

- Consequently, knowledge base is given away!

E/M Payments
2018 Medicare

- 99201 $44.50   99211 $20.46

- 99202 $75.73   99212 $44.14

- 99203 $109.46   **99213 $85.20**

- 99204 $166.16   **99214 $125.30**

- 99205 $209.23   **99215 $167.86**

Reimbursement

- All carriers pay differently based on their own fee schedule

- Knowing the difference in a level of care will make a difference in the reimbursement.

- Difference between 99213 and 99214-~$40

- Difference between 99214 and 99215-~$42

- If just 4 more 99214's per week performed, difference in reimbursement is ~$8320.

- If JUST 5 providers coded "correctly", total difference would be ~ $41,600

Changing the Rules on Leveling of Care

- CMS announced that they are thinking of revising how a level of care is chosen
  - *Currently pick a level of care based on history, physical and medical decision with all 3 for a new patient visit and 2 of the 3 for an established visit.*
  - *Time could also be used as a key factor.*
- CMS looking at using JUST medical decision making to determine level
- AAP is actively giving comments
  - History is more involved in pediatrics due to having to obtain a history from other than the patient.
  - A more detailed history leads to more examination consequently the MDM isn't always the guiding factor.
    - *Children can present with significant symptoms but on exam nothing is found so MDM could be low but the provider did much more than a 99202 or a 99213*

What's in a history?

- Four types of history
  - ***Problem Focused****: (99201/99212)*
    - HPI = 1-3
    - ROS = 0
    - PMFSH = 0
  - ***Expanded Problem Focused****: (99202/99213)*
    - HPI = 1-3
    - ROS = 1
    - PMFSH = 0
  - ***Detailed****: (99203/99214)*
    - HPI = 4+
    - ROS = 2-9
    - PMFSH = 1 (pertinent)
  - ***Comprehensive****: (99204/99205/99215)*
    - HPI = 4+
    - ROS = 10+ (or some with statement: Remainder of systems negative)
    - PMFSH = 3 for those that require all three key factors/ 2 for all others

History of Present Illness

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

Review of Systems and PMFS

- Review of systems:
  - *ROS: cannot use the chief complaint or associated problems*
  - *Remember for a 99202/99213 need 1; 99203/99214 only need 2 (2-7)!*
  - *Need at least 10 or some with statement "remainder of systems negative" for a 99204-5/99215*
- Past Medical (PM), Family (F), Social (S)
  - *Should be pertinent to the chief complaint and associated problems*
  - *PM: typically is a review of the patients history especially medications.*
    - Important to list a PM like asthma in past if patient presents with coughing or cold symptoms
  - *F: essential if a member had a rash and patient has a rash*
    - If family member has been ill, then instead of exposure being a social history, it is a family history
  - *Coding Tip: Social history pertinent across the board: have they been exposed to anyone ill?*
    - School, day care, sports, church all count as social history

Physical Examination

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

Examination (cont)

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

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

Medical Decision Making

- Most subjective part of leveling of care.
- Also requires three factors!
  - *Risk of Complications*
  - *Diagnosis or management options*
  - *Amount or complexity of data to be reviewed*
- Two of the three have to match
- If have two different levels MDM goes down, not up.

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

Risk of complications	Number of DX and / or mgmt options	Amt. and / or complexity of data to be reviewed	Level of MDM
Minimal	(PTS / ITEMS) 1 pt Minimal 　　1 self limited 　　1 est. probl	1 pt Order and / or review lab 1 pt Order and / or review radiology test	
Low	2 pts Low 　　2 self limited / minor 　　2 est. problems 　　1 est. worsening 　　1 stable chronic	1 pt Order and / or review other tests- 　　　　 EKG / PFT 2 pts Direct visualization and independent 　　　　 review of image/tracing or speciment	
Moderate	3 pts Moderate 　　1 new prob. w/o add. w/u 　　3 est. problems 　　2 est. problems, one worsening	1 pt Decision to obtain old records and / 　　　　 or history other than pt 2 pts. Review and summarize old records 　　　　 and/or obtain hx other than pt	
High	4 pts High 　　1 new problem w/add w/u 　　4 est. problems 　　2 est prob. worsening Total Points_____	2 pts. Discuss case with 　　　　 other health care 　　　　 provider Total Points_____	
Minimal	1 pt Minimal	< 1 pt Minimal	Straightforward
Low	2 pts Low	2 pts Low	Low
Moderate	3 pts Moderate	3 pts Moderate	Moderate
High	4 pts High	4 pts High	High

99202/99213 visit

- HX: 3 year old with runny nose for 4 days, no fever but started coughing now. No other symptoms (CC; 2 HPI; 1 ROS): 99202/99213
- Exam: 99202/99213
  - *Gen, eyes, ent, resp, cardiac, skin*
- MDM-low (99202/**99203**/99213)
  - *DX: URI*
  - *Plan: supportive care*
    - Risk: low-acute illness
    - DX: Mod: new problem without further workup
    - Data: min.-1 pt., hx from other than patient.

99203/99214

- 9 month old presents with c/o fever for 4 days, today went up to 103. Mom states has been using Tylenol but today did not seem to help and she thinks baby is getting more fussy. Some cough this am. Worse today for sure. Seems to be urinating ok and no diarrhea. Mom says there is a child in day care with flu, unsure of what type. (4 HPI, 3 ROS, SH) detailed history – 99203/99214

- Exam: 8+ system exam (appropriate with CC and presenting problems) comprehensive exam – 99204/5/99215

- MDM: Flu A/B, Cathed u/a, urine culture
  - *UTI (positive u/a), fever*
  - *Antibiotics, continue antipyretics, fluids, watch*
  - *Risk: Moderate (RX)*
  - *DX: Moderate (2 problems, 1 worsening or 1 new problem without further work-up)*
  - *Data: low (2 pts)*
  - *MDM= moderate (99204/99214)*

- Detailed history, comprehensive exam and moderate MDM = 99203/99214

99203 or 99214

- Patient presents with sore throat (CC), fever off and on (timing) for the last 3 days (duration), Mom used some Motrin (mod. Factor), no vomiting or diarrhea (ROS-GI), no skin rashes (ROS-Skin), no ill contacts (Social) (4 HPI, 2 ROS, 1 Social) **detailed history (99203/99214 history)**

- Exam: Gen, ENT, lymph, Resp, Cardia, Abd, Neuro, Skin- 8 brief systems **– Comprehensive exam (99204/99205/99215)**

- Assessment: Strep Pharyngitis, Fever
  - *Strep Screen-positive*
  - *Antibiotic*
  - *Discussion concerning strep throat*

- **MDM : Moderate (99204/99214)**
  - *Risk: moderate-prescription drug*
  - *DX: new problem without further w/u*
  - *Data: 2 pts (1 pt lab, 1 pt hx other than pt)*

- **Hx and MDM – visit is 992214 All 3- 99203(dt hx/comprehensive exam/low)**

99205 or 99215

- *Mom is historian: 12 year old presents with c/o a severe headache (chief complaint), has had it for more than 2 days (duration), also has had nausea (assoc. S&S) and vomited X 1 (timing). Pain on scale of 10 of 10 (severity) with stabbing pain. No blurred vision, no dizziness, no Diarrhea, no resp. issues, last period normal, remainder of systems negative (10+). Has had no ill exposures (S) and no family members with migraines (F), seems to be getting these headaches frequently lately (PMH). **Comprehensive history: 4 HPI, 10+ ROS, PM,F,S- 99204/99205/99215***

- *Exam: 8+ system exam (**comprehensive exam-required with chief complaint and presenting problems)- 99204/99205/99215***

- *Assessment: Primary Stabbing Headache*

   - Order MRI of head without contrast-will contact neuro after results

   - Prescription Pain Medication

- *MDM: High **99205/99215***

   - *Risk: moderate-prescription medication*
   - *DX: high- new problem with further work up*
   - *Data: high-4 pts-1 pt MRI, 1 pt hx other than pt., 2 pts discussion with other provider*

- *Comprehensive history, exam and high MDM – **99205/99215***

Time as a Key Factor

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

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

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

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

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

Using Time as a Key factor

- Mom and Dad (without child present) come in to discuss and get counseling on their son's behavior. He is acting up at school, doing poorly at school and not getting along with other classmates.

- A brief history is obtained, there is no exam as there is no patient present. And the plan is to bring the child in for a complete evaluation.

- With history and MDM, visit would be a 99212,

- Total time in visit- 23 min with >50% spent in counseling concerning above,

- If using history/physical and MDM visit is 99212 but when using time visit becomes 99214!

When and How and What and Where to use Critical Care Codes

- **99291**: initial 30-74 minutes
- **99292**: each additional 30 minutes
- Can be used by any type of provider
- Can be used in any setting, does not have to be a critical care unit.
- The patient has to be critically ill or injured (acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the pt's condition)

A Critical Care Visit

- Patient presents in severe respiratory distress, retracting and audible wheezing as well as some cyanosis around lips. Pulse ox is 89%, Pulse: 130, difficult to count respirations-

- You are called into the room and you assess the patient, taking some history and doing an evaluation. Note starts with "Patient is critically ill due to severe respiratory distress"

- You order some oxygen, dose of steroid and start a neb treatment while you contact the ER and discuss the patient with staff

- You re-evaluate the patient who is still critically ill and needs to be hospitalized.

- EMS is contacted and you give them a report of what has happened and the plan.

- You document your note with your history, exam, assessment, who you talked to , what all you did and at the end of the note:

- **Total time in critical care: 32 min.**

Prolonged Care Non Face to Face

- **99358: 30-74 minutes of prolonged care, non-face to face .**

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

Prolonged Care for Clinical Staff!

- **99415 (45-74 min) and 99416 (each additional 30 min):** Prolonged clinical staff services with physician or other qualified health care Professional Supervision:
  - *Used when a prolonged E&M service is provided in the office setting that involves prolonged CLINICAL staff face to face time beyond the typical face-to-face time of the E/M services as stated in the code description.*
    - Physician or QHP is present to provide direct supervision of the clinical staff.
    - IE: In order to bill the 99214 and a 99415 you would need 70 min. of total time.
      - *Patient is present for breathing issues and multiple breathing treatments are performed as well as spirometry.*
      - *Patient spends 45 min of time with the clinical staff as they watch the patient carefully (time for the nebs are not counted) before and after the nebs for respiratory distress, Monitoring the heart and respiratory and O2 rate.. Patient typically will spend about 2 hours in the office.*
      - *Infant with feeding problems and clinical staff helps Mom who is very upset with breast feeding after the physician has evaluated the patient.*
      - *IV therapy in the office setting, most common.*

Newborn Care

- **99460**: Initial hospital/birthing center care, per day, for the E/M of the normal newborn infant
  - *Includes maternal and/or fetal and newborn history*
  - *Newborn physical examination*
  - *Ordering of diagnostic tests and treatments*
  - *Meetings with the family*
  - *Documentation in the medical record*

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

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

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

After Hour Codes

- **99050** :Services provided in office at times other than regularly scheduled office hours or days when office is normally closed (EG: holidays, Saturday or Sunday) in addition to basic service

- **99051**: Service (s) provided in office during regularly scheduled evening, weekend or holiday office hours, in addition to basic service

- **99053** : Service (s) provided between 10pm and 8am at 24 hour facility, in addition to basic service.

- **99058 : Service (s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service**

DON'T FORGET THOSE IMPORTANT PROCEDURES

**Can you bill for an office visit and a procedure on the same day?
YES YOU CAN, But Follow Some Simple Rules!**

- Bill a visit when the patient presents for problems and a procedure is **"needed"** to help determine a definitive diagnosis or for treatment
  - *Child presents with an injury to their left elbow, subluxation of elbow*
- **Do NOT bill for a visit when the patient presents and the procedure has already been determined to be done at this visit at a previous visit.**
  - *Removal of wart (diagnosed week prior and told to come back for removal)*
- You will need to use modifier 25 on the VISIT only.
- May need to use the 59 modifier on the procedure as well.
- **ALWAYS** use a different diagnosis code for the visit and procedure.
- **REMEMBER: you have to make a separate notation for the procedure**
  - *How procedure was performed*
  - *Results*
  - *How tolerated*

Minor Procedures

- **20600:** Arthrocentesis: bursa or small joint ($57)
- **20605**:   ", intermediate joint ($61)
- **20610**:   ", large joint ($71)
- **11730:** Avulsion of nail plate, partial or complete, simple, single ($131)
  - ***11732**:   each additional nail plate*
- **11740**: Evacuation of subungual hematoma ($63)
- **28190**: FB-foot ($268.00)
- **30300**: FB-nose ($225)
- **11200**: Skin tag removal; up to 15 lesions ($110)
- **41010**: Incision in the lingual frenulum to free the tongue ($260) dx Q38.1
- Application of splints:
  - *Short arm splint (forearm to hand): static-**29125 ($81)** dynamic-**29126 ($96)***
  - *Finger splint: static- **29130** ($49) dynamic-**29131 ($64)***
  - *Short leg splint (calf to foot): **29515 ($88)***
  - ***A4570**: Splint   **S8450-S9452**: Splint, prefabricated for finger, wrist, ankle or elbow*
- Strapping
  - *Shoulder: **29240 ($36)***
  - *Elbow or wrist: **29260 ($36)***

Nursemaid Elbow

- **24640:** Subluxation of radial head, closed treatment with manipulation
  - *Nursemaid elbow*
  - *IE: Patient presents with a history of injury to left arm-was swinging on the monkey bars at a park and someone grabbed her to drag her off. Child states cannot use arm at all, pain esp at the elbow and unable to straighten arm. Mom concerned arm is broken*
    - History and exam performed and it is determined that there needs to be a reduction of the radial head
    - The Patient/Parents are explained the procedure and with proper technique the subluxation of the left elbow was performed with immediate pain relief. Patient Tolerated the procedure well.
      - *S53.002A: Subluxation of the left radial head, initial encounter*
      - *W09.8XXA: Fall from equipment on the playground, initial encounter*
  - *10 day post op*
  - *$121*

Other Minor Procedures

- **10060**: Incision and Drainage, Simple
  - *Used when there is a cellulitis/abscess that needs to be drained.*
  - *10 post op days ($146)*
- **17250:** Chemical Cauterization of Granulation Tissue
  - *14 day old infant presents for a sick visit because Mom is stating the baby is bleeding from the abdomen! On evaluation the physician notices there is a granuloma on the umbilicus, using a silver nitrate stick they cauterize the umbilical granuloma*
    - **ICD-10: P83.81: umbilical granuloma**
  - *0 post op days*
  - *$102 payment from Medicare*

Removal of Impacted Cerumen
There are 2 codes now!!!

- **69209:** New Code: Removal impacted cerumen using irrigation/lavage, unilateral
    - Use modifier 50 if bilateral
    - Remember that the wax has to be impacted.
    - $18

- **69210**: Removal impacted cerumen _requiring instrumentation_, <u>unilateral</u>
    - <u>$58</u>

  - _Use modifier 50 if cerumen is removed from both ears_
      - 69210
      - 69210-50

- Both still have to be documented

- Cannot report both together
  - _IE: Attempted to remove impacted cerumen per lavage and then instrumentation was used-bill only the 69210._

- ICD-10
  - _H61.21-3 for right, left and bilateral_

Developmental Screening

- 96110: Developmental Screening (eg: developmental milestone survey, speech and language delay screen), per standardized instrument
  - *Revised: use to state 'with interpretation scoring and report documentation, per form'*
  - *Most Carriers follow Bright Futures recommendations on timing*
    - Typical standardized instruments:
      - *MCHAT*
        - 18 mo., and 24 mo
      - *ASQ (Ages and Stages)*
      - *Early language milestone screen*
      - *PEDS (Parent Evaluation and Developmental Status)*
      - *ASAS (Australian Scale for Asperger's Syndrome)*
      - *BRIEF (Behavioral Rating Inventory of Executive Functioning)*
      - *BASC-II (Behavior Assessment Scale for Children)*

Emotional and Behavioral Code

- 96127: Brief emotional and behavioral assessment (eg: depression inventory, attention-deficeit disorder/hyperactivity (ADHD scale) with scoring and documentation, per standardized form
  - *GAPS questionaire (Guidelines for Adolescent Preventive Services Questionaire)*
    - Used between ages 11-21
      - *http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf*
  - *SDQ (Strengths and Difficulties Questionaire)*
    - The SDQ is a brief, free-of-charge, questionnaire consisting of 25 items assessing positive and negative attributes on five scales (emotional, conduct, hyperactivity, peer problems, and prosocial behavior). It takes 5-15 minutes to administer.
  - *See "Guidelines for Adolescent Depression in Primary Care"*

Health Risk Assessment Codes

- 96160: Replaces 99420: now patient focused
  - *Administration of patient-focused health risk assessment instrument (eg. Health hazard appraisal-SCAT, SCAT 2 and SCAT 3 for children under 12) with scoring and documentation, per standardized instrument) ($4.67)*

- 96161: Also Replaces 99420: now caregiver-focused
  - *Administration of caregiver-focused health risk assessment instrument (eg: depression inventory-Edinburgh) for the benefit of the patient, with scoring and documentation, per standardized instrument. ($4.67)*

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

AND HERE'S ICD-10!

Let's Talk Diagnosis Coding:
Recap!

- Always use codes at the highest level of specificity
  - *Realize that SOME of our dx codes cannot be specific!*
- Use more than one diagnosis as appropriate
  - *Those that are pertinent to the visit for that date*
- Z codes can be for information only or payable
- Chapter 19: S and T codes for injuries, accidents
  - *Typically will need another code or more from Chapter 20*
  - *V, W, X and Y codes*

7th Digit Episode of Care

- **7th Characters**
  - *Injuries and poisonings will want a 7th digit episode of care*
  - ***Do not use the Z code (Z48.02) for suture removal!!!***
    - **Use the appropriate S code with the D if removing sutures to identify the subsequent care**
  - *The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instructs.*
  - *The 7th character MUST ALWAYS be the 7th character in the data field.*
  - *If a code that requires a 7th character is NOT 6 characters, a placeholder X must be used to fill in the empty characters.*
  - *The following 7th character extensions are to be added to each code for this category*
    - A initial encounter: initial encounter is defined as the period when a patient is receiving active treatment for an injury, poisoning or other consequences of an external cause. An "A" may be assigned on more than one claim. For example, consider a patient seen in the emergency department (ED) for a head injury that first is evaluated by an ED physician. If the ED physician requests a CT scan that subsequently is read by a radiologist , and then you see them in follow up, the seventh character "A" is used by all three physicians and also reported on the ED claim. The **A is used for the entire period when the patient receives active treatment**.
    - D: subsequent encounter: Subsequent encounter ("D"): this is an encounter occurring **after the active phase of treatment**, when a patient is receiving routine care during a period of healing or recovery. For example, a patient with an ankle sprain may return to the office to have joint stability re-evaluated to ensure that the injury is healing properly
    - S: sequela: is assigned for complications or conditions arising as a direct result of an injury. An example of a sequela is a scar resulting from a burn.

A Few Great Codes for 2018

- Although not seen as often as before the vaccine, with people not vaccinated for chicken pox, could see this again.
  - ***G93.7 Reye's syndrome Code first***
    - (T39.0-), if salicylates-induced poisoning due to salicylates, if applicable (T39.0-, with sixth character 1-4)
    - **Use Additional** code for adverse effect due to salicylates, if applicable (T39.0with sixth character 5)
- **L92.9 Granulomatous disorder of the skin and subcutaneous tissue, unspecified**
  - ***Excludes2: umbilical granuloma (P83.81)***
- **R06.03 Acute respiratory distress**
- **R63.3 Feeding difficulties**
  - *Now added Picky eater to this code*
- **R68.13 Apparent life threatening event in infant (ALTE)**
  - *Add Brief resolved unexplained event (BRUE)*

ICD-10 Information For Neonates

- There are 441 ICD-10-CM codes intended for newborns and/or neonates of age 0 years as each code is clinically and virtually impossible to be applicable to patients of any age greater than this.

- P00.9: Newborn affected by unspecified maternal conditions (new
  - ***P00.89 newborn affected by other maternal conditions***
  - *Great new Z codes to "rule out" issues with the neonate.*
    - Z05.0 Observation and evaluation of newborn for suspected cardiac condition ruled out
    - Z05.1 Observation and evaluation of newborn for suspected infectious condition ruled out
    - Z05.2 Observation and evaluation of newborn for suspected neurological condition ruled out
    - Z05.3 Observation and evaluation of newborn for suspected respiratory condition ruled out
    - Z05.41 Observation and evaluation of newborn for suspected genetic condition ruled out
    - Z05.42 Observation and evaluation of newborn for suspected metabolic condition ruled out
    - Z05.43 Observation and evaluation of newborn for suspected immunologic condition ruled out
    - Z05.5 Observation and evaluation of newborn for suspected gastrointestinal condition ruled out
    - Z05.6 Observation and evaluation of newborn for suspected genitourinary condition ruled out
    - Z05.71 Observation and evaluation of newborn for suspected skin and subcutaneous tissue condition ruled out
    - Z05.72 Observation and evaluation of newborn for suspected musculoskeletal condition ruled out
    - Z05.73 Observation and evaluation of newborn for suspected connective tissue condition ruled out
    - **Z05.8 Observation and evaluation of newborn for other specified suspected condition ruled out**
    - Z05.9 Observation and evaluation of newborn for unspecified suspected condition ruled out

Don't Forget These "Old" Codes

- **Z03.89: Encounter for observation of a specified condition, ruled o**ut

- Z13.89: Encounter for screening for other disorder

- **Z79.899: Long term use of current medication**
  - *Use instead of mental health codes if patient is on medication for treatment.*

- Use the observation code for the neonate presenting at 3-5 days of age without issues

- Abdominal Pain,
  - *Rt Upper Quadrant: R10.11*
  - *Lt Upper Quadrant: R10.12*
  - *Rt Lower Quadrant: R10.31*
  - *Lt Lower Quadrant: R10.32*
  - *Periumbilical : R10.33*
  - *Epigastric : R10.13*
  - *Generalized: R10.84*

Signs and Symptoms

■ Symptoms and signs involving emotional state

  – *R45.0 Nervousness*

  – *R45.1 Restlessness and agitation*

  – *R45.2 Unhappiness*

  – *R45.3 Demoralization and apathy*

  – *R45.4 Irritability and anger*

  – *R45.5 Hostility*

  – *R45.6 Violent behavior*

  – *R45.7 State of emotional shock and stress, unspecified*

  – *R45.8 Other symptoms and signs involving emotional state*

  – *R45.81 Low self-esteem*

  – *R45.82 Worries*

  – *R45.83 Excessive crying of child, adolescent and adult*

Signs and Symptoms involving appearance and behavior

- R46.O   Very low level of personal hygiene
- R46.1   Bizarre personal appearance
- R46.2   Strange and inexplicable behavior
- R46.3   Overactivity
- R46.4   Slowness and poor responsiveness
- R46.6   Undue concern and preoccupation with stressful events
- R46.7   Verbosity and circumstantial detail obscuring reason for contact
- R46.8   Other symptoms and signs involving appearance and behavior
  - *R46.81   Obsessive-compulsive behavior*

Sick Visits

- **New Patient Visit-need all 3**
- (HPI: Duration/Location/Assoc. S&S/ Modifying Factor/Quality/Timing
-     Severity/ Context)
- **99201- 10 min. (6 for time)**
  - HX: HPI-1-3
  - Exam: 1 system
  - MDM-straightforward
- **99202: 20 min (16 for time)**
  - HX: HPI 1-3, 1 ROS
  - Exam: 2-7 brief systems
  - MDM: low
- **99203: 30 min (26 for time)**
  - HX: HPI 4+, 2-9 ROS, 1 PMFS
  - Exam: 1 sys. Detail, 2-7 brief sys.
  - MDM: Low
- **99204: 45 min (38 for time)**
  - HX: HPI 4+. 10+ ROS, All 3 PMFS
  - Exam: 8 systems
  - MDM: Moderate
- **99205: 60 min (53 for time)**
  - HX: 4+ HPI, 10+ ROS, all 3 PMFS
  - Exam: 8 systems
  - MDM: High

- **Est. Patient Visit-2 of 3**
- (HPI: Duration/Location/Assoc. S&S/ Modifying Factor/Quality/Timing
-     Severity/ Context)
- **99212L 10 min (6 for time)**
  - HX: HPI 1-3
  - Exam: 1 system
  - MDM: straightforward
- **99213: 15 min (13 for time)**
  - HX: HPI 1-3, 1 ROS
  - Exam: 2-7 brief systems
  - MDM: Low
- **99214: 25 min (21 for time)**
  - HX: HPI 4+, 2-7 ROS, 1 of PMFS
  - Exam: 1 in detail, 2-6 others brief
  - MDM: Moderate
- **99215: 40 min (33 for time)**
  - HX: HPI 4+, 10+ ROS, 2 of 3 PMFS
  - Exam: 8 + systems
  - MDM: High

MDM: 2 of 3 determine code

- **Risk**
  - *Straightforward- (99201/99212*
    - **Lab test-veni-punc**
    - **Drsg**
    - **1 self limited**
  - *Low- (99202/99203/99213)*
    - **acute uncomplicated problem**
    - **1 stable chronic**
    - **Lab test-art. punc./x-ray**
  - *Moderate (99204/99214)*
    - **1 chronic with mild exacerbation**
    - **Prescription drug**
    - **MRI/CT**
    - **Closed TX of FX**
  - *High (99205/99215)*
    - **1 chronic with severe exacerbation**
    - **ER major surgery**
    - **Acute illness with threat to life and limb**

- **Diagnosis-list all appropriate**
  - *Straightforward (99201/99212)*
    - **1 self limited**
    - **1 est. prob, stable**
  - *Low (99202-3/99213)*
    - **1 est.worsening**
    - **2 est. prob.**
    - **1 stable chronic**
  - *Moderate (99204/99214)*
    - **New prob. w/o further w/u**
    - **2 est. prob., 1 worsening**
    - **3 est. problems**
  - *High (99205/99215)*
    - **New with further w/u**
    - **4 est prob/2 est both worse**

- **Data**
  - *Straightforward (99201/99212) 1 pt.*
    - **Lab/xray/other tests -1 pt**
    - **Review**
    - **Hx other than patient**
  - *Low (99202-3/99213) -2 pts*
    - **Direct visualization of spec/image**
    - **Discuss case with healthcare professional**
  - *Moderate (99204/99214) - 3 pts*
  - *High (99205/99215) – 4 pts.*

AND NOW FOR QUESTIONS???