

PEDIATRIC CODING ALERT

Your practical adviser for ethically optimizing coding, payment, and efficiency in pediatric practices

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Report 99050 for 'Above and Beyond' Care and Reap the Benefits

▶ **Highlight the phrase "in addition to basic service"—you'll be glad you did.**

Pediatricians don't always see patients during regular office hours, which means you may be left with a coding headache. If you're confused by the differences between 99050 and similar codes — or don't think they're worth reporting — read on for some real-world advice.

Watch the Clock for 99050

When looking at after-hours codes, your first choice often will be 99050 (*Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed [e.g., holidays, Saturday or Sunday], in addition to basic service*). Code 99050 comes into play when the physician sees the patient in the office during hours when the office normally would be closed.

Example: Your practice usually closes at 4 p.m. on Wednesday, but the pediatrician sees a patient at 6 p.m. If your posted closing time is 4 p.m., you can report 99050 for the 6 p.m. visit along with the appropriate treatment codes.

Caveat: You can only consider reporting 99050 if the patient can only come after your normal office hours end. "If you see him after hours because the doctor is running behind or because of similar issues, the patient isn't considered 'after hours,'" explains **Victoria S. Jackson**, a practice management consultant with JCM Inc. in California. "But if the parent calls for an appointment and asks if you can see the child late because she can't get there until 6 p.m., that's after hours."

Non-Standard Business Hours Could be 99051

If your practice has routine hours for seeing patients in the evenings or on weekends or holidays, don't forget about 99051 (*Service[s] provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service*).

Example: Your office stays open until 9 p.m. on Thursday evenings. A patient who comes at 7 p.m. is still within your posted office hours, but outside "usual business hours." Explain the situation to your payer by including 99051 on the claim.

(continued on next page)

“This rule changed a few years back and people are confused by it,” says **Chip Hart**, director of Pediatric Solutions in Winooski, Vt. “They don’t understand that they can bill a 99051 any time it’s after hours.”

CPT doesn’t clearly define “after hours times,” which adds to the confusion. “When people ask, ‘When is after hours?’ I tell them it’s when the insurance company stops answering the phone,” Hart adds.

Caution: Most large plans don’t recognize 99051, says **Richard Lander, MD, FAAP**, a pediatrician at Essex-Morris Pediatric Group in Livingston, N.J. Some payers do recognize it when reported with an office visit code (99212-99215), he says, but not with all well visits (99381-99395).

Office Emergency Points to 99058

Think “emergency” and “interruption” when considering whether to include 99058 (*Service[s] provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service*) on a claim.

“99058 is for a true emergency or when the doctor needs to see the patient right then,” Jackson says. “It could be because the mom is demanding it, or could be because

the child is screaming in pain or has a serious laceration or other problem.”

Tip: Cases that merit 99058 are urgent care situations that disrupt the office schedule, such as a child with asthma who is experiencing active wheezing and shortness of breath (493.02, *Extrinsic asthma; with [acute] exacerbation*). The patient’s parent could bring the child himself, or another physician office could call saying the patient needs to be seen right away. Be sure the pediatrician adequately documents the situation, however, before submitting 99058 — payers want to know that the physician treated the patient for an emergent problem and fit the child into the schedule because of that problem.

Fine line: Don’t routinely report 99058 for walk-in patients. The child must present with an acute problem that needs assessment and treatment before meriting 99058.

Remember to Include E/M Codes

At first glance, codes 99050, 99051, and 99058 seem comprehensive enough to stand on their own. Take a closer look, however, and the phrase “in addition to basic service” is your clue that more codes are needed.

CPT doesn’t designate the status with a plus sign, but the codes technically are considered add-on codes.

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Therefore, you can only report them in conjunction with the appropriate E/M code.

Hold Out for Reimbursement

Some payers, including Medicare, do not reimburse for the after-hours codes — but others do.

Example: Medicaid Ohio pays for 99050, as do many other payers. Fewer pay for 99051 and 99058, but don't give up hope. Coverage and payment amounts can be regionally and payer specific, but can be negotiated at contract time.

Reimbursement rates might not be high, but every little bit adds up. You can also use what payments you are receiving to help garner more from non-payers. "Even if you aren't being paid right now by BCBS, wouldn't you like to count all those codes so that the next time you sit down for your negotiation with them, you have the data?" Hart asks. "Every one of those 9905x codes saves the insurance company hundreds or thousands of dollars in the ER."

"I strongly encourage practices to open up early-morning and after-work well visit slots for working

families," Hart adds. "Get those important well visits, make your families happy, and collect a well-deserved premium. It's good business, but more importantly, it's good medicine." □

Breathe Easy Knowing You're Updated on Common Spirometry Tests

► **Hint: You might not need as many codes on the claim as you expect.**

CPT 2010 lists several codes for spirometry testing under "Other Procedures" in the Medicine section. The next time you're faced with determining the best code for a patient, be sure you know the differences between these most-common options — and which codes you don't need to include on your claim.

Look to 94010 As Your First Choice

When coding spirometry, the most frequent choice for most pediatricians is 94010 (*Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement[s], with or without maximal voluntary ventilation*).

Scenario: An established patient presents for a follow-up visit after an episode of respiratory distress where she needed a nebulizer or inhaler treatment. The staff evaluates the child's respiratory status at that visit and treats the child. You report 94010 along with an E/M code for the office visit; experts say the child's significant subsequent management merits 99214 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity ...*).

"You don't usually do spirometry when the patient is in acute distress because the reading will be low," says **Richard L. Tuck, MD, FAAP**, a pediatrician at PrimeCare of Southeastern Ohio in Zanesville. "You complete a spirometry test when the patient is stable, usually in a follow-up visit."

(continued on next page)

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Distinction: Providers sometimes struggle with how to bill for peak expository flow and wonder if they can report 94010 for the service. This is incorrect, because peak flow measurement (using a peak flow meter) is considered part of the E/M service. Spirometry, by contrast, is using a standardized instrument with a hard copy report and interpretation that becomes part of the patient's record, Tuck explains.

Go Straight to 94060 for Pre- and Post-Tests

Sometimes a single treatment or test is enough; the pediatrician wants more information. In that case, she'll administer a simple spirometry test, treat the patient with an inhaled bronchodilator, and conduct a follow-up spirometry test. This pre/post test approach is useful in establishing an asthma diagnosis.

"When we do a pre/post test, we use code 94060," says **Suzanne Wood, CPC**, with Pulmonary Associates Medical Group in La Mesa, Cal. Again, report 94060 (*Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration*) with the appropriate E/M code.

Modifier tip: When the pediatrician completes a service in addition to E/M care, payers often require you to append modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) to the E/M code. Wood and other coders, however, find that including modifier 25 with 94010 and 94016 is unnecessary. "I have no trouble getting paid in addition to an E/M service and I do not need to use a 25 modifier," Wood says. Check your payer's guidelines before filing your claim.

Supervision status: Code 94060 requires direct supervision. Ensure that a physician is present in the office suite and is immediately available to furnish assistance and direction throughout the procedure as needed.

Watch for Chances to Use 94664

Patients who use inhalers on a regular basis need to know they're using the equipment correctly, especially when you're dealing with children.

"If the child comes in for a well visit, ask how they use their inhaler," suggests **Victoria S. Jackson**, a practice management consultant with JCM Inc. in California.

"Show them how to use it correctly if necessary and report 94664."

A trained non-physician practitioner (NPP) or physician can perform the demonstration. Provide appropriate documentation in either situation, and have the supervising physician countersign the NPP's notes.

Bonus: Taking that simple step with your established patients can garner extra pay each time you report 94664 (*Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device*). Currently, the national adjusted Medicare fee for non-facility service is \$14.07, so check your other payers' fee schedules. You can repeat education at future visits as necessary to ensure optimal use of an aerosol machine or metered dose inhaler.

Modify it: You might need to append modifier 59 (*Distinct procedural service*) to 94664, especially when you provide education and give an aerosol treatment during the same visit. "Some payers want to say that 94664 is included in 99460, but you don't really teach at the same time," Tuck says. "You treat the acute problem and decide that the patient needs ongoing aerosol treatments. That requires separate education, so you need to include modifier 51 to get paid." □

News You Can Use:

Treating Pneumococcal Infections? Prevnar 13 Replaces Prevnar 7

► **Find out what corresponding V code you should report with 90670.**

Get ready to change your thinking about Prevnar, because the FDA has approved the Prevnar 13 vaccine for pneumococcal infections. Prevnar 13 (PCV13) replaces Prevnar 7 (PCV7).

Prevnar 13 adds protection against six more strains of the pneumococcal bacteria, according to *The New York Times*. The 13 valent vaccine has improved coverage for pediatric pneumococcal infections, including otitis media (382.x, *Suppurative and unspecified otitis media*).

Keep these key points in mind as you begin offering Prevnar 13:

- The correct CPT code is 90670 (*Pneumococcal conjugate vaccine, 13 valent, for intramuscular use*).
- The corresponding V code is V03.82 (*Other specified vaccinations against single bacterial diseases; streptococcus pneumoniae [pneumococcus]*).
- With implementation underway, start contacting your payers about recognition and appropriate payment. It's a tedious task, but important for every group.
- As with the older vaccine, Prevnar 13 is given by intramuscular injections at 2 months, 4 months, 6 months, and between 12 and 15 months of age.
- An immunization advisory committee for the Centers for Disease Control and Prevention recommended that all children less than 5 years of age who received the Prevnar 7 vaccine should get a supplemental dose of Prevnar 13 the next time they visit the doctor, up to 59 months of age. □

READER QUESTIONS

Your Depression Diagnosis Depends on Physician

Question: *We see a patient each week to monitor her medication for depression. What is the best diagnosis code for these visits since we don't want to use a depression diagnosis?*

Oklahoma Subscriber

Answer: The appropriate diagnosis depends on the type of physician seeing the patient. If the physician is a psychologist, report V67.3 (*Follow-up examination; following psychotherapy and other treatment for mental disorder*). For other physicians, submit V58.69 (*Long-term [current] use of other medications*).

The corresponding CPT code for managing the patient as described is 90862 (*Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy*).

Note: If your provider sees a patient on a regular basis for medication follow-up, you'll reach a point where it's no longer appropriate to only code the patient's symptoms (unusual weight loss or gain, headache, fatigue, or other associated mental health issues). Once the patient has

an official diagnosis of depression or another mental condition, you'll need to be straightforward in reporting that diagnosis.

Turn to 271.8 for 3-MCC Diagnosis

Question: *What is the best diagnosis for 3-MCC (3-Methylcrotonyl-Coenzyme A carboxylase deficiency)?*

Arizona Subscriber

Answer: Your best choice is 271.8 (*Other specified disorders of carbohydrate transport and metabolism*).

3-MCC is an uncommon, inherited disorder in which the body is unable to process certain proteins correctly because of a shortage of leucine. Infants with 3-MCC deficiency appear normal at birth but develop signs and symptoms in infancy or early childhood.

Characteristic features of 3-MCC include feeding difficulties, recurrent episodes of vomiting or diarrhea, excessive tiredness, and weak muscle tone.

Go With 94760 for Pulse Oximetry

Question: *We are beginning to offer oxygen saturations and pulse readings in the office. How should we code for this?*

Maryland Subscriber

Answer: You'll report pulse oximetry with 94760 (*Noninvasive ear or pulse oximetry for oxygen saturation; single determination*). File the claim as appropriate, but know that some insurance companies don't reimburse because they follow the CMS determination that E/M work includes pulse oximetry.

(continued on next page)

You Be the Coder

Reporting 69200 As A Bilateral Procedure

Question: *Is 69200 a bilateral procedure, or do we need to include a modifier if the pediatrician removes foreign bodies from both ears?*

Arkansas Subscriber

Answer: Consider your answer, then turn to page 31 for the answer. □

Insurance companies that do reimburse don't pay much. For example, the national average non-facility payment according to the Medicare Physician Fee Schedule is \$2.53. Regardless of payment, always include 94760 on your claim when applicable because it supports a higher level of medical decision making.

Multiple option: If you test pulse oximetry multiple times, such as before and after an aerosol treatment, code with 94761 (... *multiple determinations [e.g., during exercise]*) instead.

82962 Can Be OK for Home Use

Question: *A payer denied our claim for 82962. Is there any way to get paid for it?*

Connecticut Subscriber

Answer: Check with your payer, because 82962 (*Glucose, blood by glucose monitoring device[s] cleared by the FDA specifically for home use*) should be acceptable; many physician offices report 82962 despite the notation of "specifically for home use."

Definition: Code 82962 represents the method when whole blood is obtained (usually by finger stick device) and assayed using a small portable device. By contrast, 82948 (*Glucose; blood, reagent strip*) describes a blood glucose level obtained by a reagent strip method.

Yes, You Can Bill TB Test Check

Question: *We were told that we could bill Medicaid when our physician reads TB test results. Is this true?*

New York Subscriber

Answer: Yes, you can bill for the test reading as a separate E/M visit. Report 99211 (*Office or other outpatient visit for the evaluation and management of an established patient, that may or may not require the presence of a physician. Usually, the presenting*

Newsletter Question or Comment?



If you have a question or comment about the contents of this publication, please contact the editor, Leigh DeLozier, CPC, at leighd@inhealthcare.com.

problem[s] are minimal ...). Although 99211 represents a minimal encounter, *CPT Assistant* supports billing the service.

Include V74.1 (*Special screening examination for bacterial and spirochetal diseases; pulmonary tuberculosis*) to explain the encounter.

Include Supporting Symptoms for Metabolic Test

Question: *A locum tenens who filled in while our pediatrician was out of the office noted "metabolic screening" on the patient's chart. What's the best diagnosis for a metabolic screening, and do we need to include additional diagnoses as support?*

Washington Subscriber

Answer: ICD-9 includes two codes for metabolic screening: V77.7 (*Special screening for endocrine, nutritional, metabolic, and immunity disorders; other inborn errors of metabolism*) and V77.99 (... *other and unspecified endocrine, nutritional, metabolic, and immunity disorders*). Choose between these codes for your first diagnosis, based on the reason for testing.

Add to it: Bolster your claim by including codes for other symptoms the physician included in the chart. For example, symptoms such as lethargy (780.79, *Other malaise or fatigue*) or low weight gain (such as 783.41, *Failure to thrive*) might indicate the need for hypothyroidism screening.

Parental Concern Offers Behavior Visit Clues

Question: *Parents sometimes come to the office to talk with our physicians about the child's behavior. The physician often lists "behavior concerns" as the diagnosis, but that's not in ICD-9. What's the best diagnosis for these visits?*

Missouri Subscriber

Answer: Some possibilities include codes from 312.xx (*Disturbance of conduct, not elsewhere classified*), 313.xx (*Disturbance of emotions specific to childhood and adolescence*), and 315.xx (*Specific delays in development*). Other options include new codes from the 799.2x family (*Signs and symptoms involving emotional state*). Check the physician's documentation of the main reason for the

parent's concern (such as aggressive behavior, trouble in school, not staying focused, etc.) and code specifically from there.

781.99 Is Best Sensory Integration Disorder Choice

Question: *What diagnosis should we submit for sensory integration disorder?*

Nevada Subscriber

Answer: Sensory integration disorder is not a recognized diagnosis in ICD-9, so the most accurate choice is 781.99 (*Other symptoms involving nervous and musculoskeletal systems*).

Also known as sensory integration dysfunction, SID is a neurological disorder that results from the brain's inability to integrate certain information received from the body's five basic sensory systems. Physicians often detect SID in young children. Signs can include (but are not limited to) oversensitivity to touch, movement, sights, or sounds; a tendency to be easily distracted; an activity level that is unusually high or unusually low; difficulty in making transitions from one situation to another; and delays in speech, language, or motor skills or academic achievement.

Remember Modifiers for 99391 With 17250

Question: *What is the correct way to bill 99391 and 17250 during the same encounter in the office? Does it require a modifier?*

California Subscriber

Answer: You'll need to separate the services on your claim and, yes, you'll need a modifier. Start with the applicable E/M service from 99211-99215 (*Office or other outpatient visit for the evaluation and management of an established patient ...*) and append modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*). Next, report 99391 (*Periodic comprehensive preventive medicine reevaluation and management of an individual ...*) with the appropriate diagnosis, such as 771.4 (*Omphalitis of the newborn*). Lastly, report 17250 (*Chemical cauterization of granulation tissue [proud flesh, sinus or fistula]*). You'll

need separate documentation with the diagnosis and separate procedure notes to round out your claim.

Look to 96110 for M-CHAT Screening

Question: *What is the best code for administering the M-CHAT screening? Do we need to include a modifier?*

West Virginia Subscriber

Answer: Submit 96110 (*Developmental testing; limited [e.g., Developmental Screening Test II, Early Language Milestone Screen], with interpretation and report*) when you administer the Modified Checklist for Autism in Toddlers (M-CHAT), and include the appropriate E/M code. If you administer another screening during the same visit (such as the ASQ, Ages and Stages Questionnaire), report 96110 again and append modifier 59 (*Distinct procedural service*). Multiple screenings typically occur at a child's 10-month visit, following Bright Future Guidelines.

Choose Consult Code for Surgery Prep Visit

Question: *Humana denied our claim with 99212 and diagnosis V70.3. Should we code medical clearing for surgery differently?*

Wisconsin Subscriber

(continued on next page)

You Be the Coder

(Question on page 29)

Reporting 69200 As A Bilateral Procedure

Answer: Code 69200 (*Removal of foreign body from external auditory canal; without general anesthesia*) is not a bilateral one, which means you can report it twice if the provider removes objects (such as beads) from both ears. Append modifier 59 (*Distinct procedural service*) to the second code.

Careful: Don't confuse 69200 for foreign body removal with 69210 (*Removal impacted cerumen [separate procedure], 1 or both ears*). Foreign body removal does not include cerumen, which is why you'll report 69200 instead. □

Answer: Because your physician is consulting with the patient and family about surgery, a better choice would be 99242 (*Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making*). You can still include V70.4 (*Examination for medicolegal reasons*) with documentation explaining the encounter.

Note: Reporting consultation codes is an area of concern for some practitioners because of Medicare's decision to stop paying for the service. However, most private payers have not followed Medicare's decision and continue to pay for consultation codes at this time.

Clarification

As discussed in *Pediatric Coding Alert* (Vol. 13, No. 3), you can bill multiple instances of +90472 (*Immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; each additional vaccine [single or combination vaccine/toxoid] [List separately in addition to code for primary procedure]*). Just be sure to report 90471 for the first vaccine injection, then +90472 for each additional vaccine. □

— *Answers for You Be the Coder and Reader Questions were reviewed by Richard Tuck, MD, FAAP, pediatrician at PrimeCare of Southeastern Ohio in Zanesville.* □

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