CPT Pediatric Coding Updates 2012

The 2012 *Current Procedural Terminology* (CPT) codes are effective as of January 1, 2012. This is not an all inclusive list of the 2012 changes. TNAAP has listed below the codes we believe are of most interest to general pediatricians.

► - New or Revised text
● - New code
▲- Revised code

New or Revised Language

Instructions for Use of the CPT Book

- CPT 2012 Defines "qualified healthcare professional"
- Codes **90460** and **90461** or other services that include the terminology "qualified healthcare professional" in their definition should not be reported unless a physician (or clinical nurse practitioner with his or her own provider number) performs and documents the service.

►A "physician or other qualified healthcare professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff". A clinical staff member is a person who works under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services.

Evaluation and Management (E/M) Services

Guidelines

- A revised definition for a new patient clarifies that a new patient is one who has not received patient services from the physician or another physician of the "exact" same specialty "and subspecialty" who belongs to the same group practice.
- The decision tree, which was removed from the 2011 manual, has been reinserted in CPT 2012. It provides guidance for selecting a new patient (**99201-99205**) versus an established patient (**99211-99215**) office or outpatient code.

New and Established Patient

►Solely for the purposes of distinguishing between new and established patient, **professional services** are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who had not received any professional services from the physician

or another physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

►An established patient is one who has received professional services from the physician or another physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree. (CPT book)

Hospital Observation Services

- Typical times have been added to initial observation care codes (**99218-99220**). The assigned times mirror those in the initial hospital care codes (**99221-99223**).
- Physicians may report initial observation care using time as the key controlling factor when more than 50% of the total face-to-face encounter (eg, floor/unit time) is spent in counseling or coordination of care.

Initial Observation Care

▲99218 Physicians typically spend **30** minutes at the bedside and on the patient's hospital floor or unit.

▲99219 Physicians typically spend **50** minutes at the bedside and on the patient's hospital floor or unit.

▲99220 Physicians typically spend **70** minutes at the bedside and on the patient's hospital floor or unit.

Prolonged Services

- Editorial revisions have been made to prolonged service codes (**99354-99359**). The introductory guidelines clarify the definition of *direct patient contact*. References to the term *face-to-face* have been removed.
- Prolonged service inpatient add-on codes **99356** and **99357** may be reported in addition to subsequent observation codes (**99218-99220, 99224-99226**). Although observation care services are performed in an outpatient setting, intra-service times for the codes are defined as unit/floor time rather than face-to-face time as required in the office or outpatient setting. However, note that when consultations are performed in the observation setting, office or outpatient prolonged service codes (**99354** and **99355**) will be reported if appropriate.

Prolonged Physician Service with Direct Patient Contact

►Codes **99354-99357** are used when a physician or other qualified health care professional provides prolonged service involving direct patient contact that is provided beyond the usual service in either the inpatient or outpatient setting. Direct patient contact is face-to-face and includes additional non-face-to-face services on the patient's floor or unit in the hospital or nursing facility during the same session. This service is reported in addition to the designated

E/M services at any level and any other services provided at the same session as E/M services. Appropriate codes should be selected for supplies provided or procedures performed in the care of the patient during this period.

►Codes **99354-99355** are used to report the total duration of face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service in the office or other outpatient setting, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Codes **99356-99357** are used to report the total duration of time spent by a physician or other qualified health care professional at the bedside and on the patient's floor or unit in the hospital or nursing facility on a given date providing prolonged service to a patient, even if the time spent by the physician or other qualified health care professional on that date is not continuous.

►**99354** and **99356** should only be used once per date, even if the time spent by the physician or other qualified health care professional is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the E/M codes.

▲99354 Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient E/M service)

▲99355 each additional 30 minutes (List separately in addition to the code for prolonged service.)

▲99356 Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to the code for inpatient E/M service.)

▲99357 each additional 30 minutes (List separately in addition to the code for prolonged service.)

Prolonged Service without Direct Patient Contact

►Codes **99358** and **99359** are used when a prolonged service that is neither face-to-face time in the office or outpatient setting, nor additional unit/floor time in the hospital or nursing facility setting during the same session of an E/M service and is beyond the usual physician or other qualified health care professional service time.

►This service is to be reported in relation to other physician or other qualified health care professional services, including E/M services at any level. This prolonged service may be reported on a different date than the primary service to which it is related. For example, extensive record review may relate to a previous E/M service performed earlier and commences on receipt of past records. However, it must relate to a service or patient where (face-to-face)

patient care has occurred or will occur and relate to ongoing patient management. A typical time for the primary service need not be established within CPT code set.

►Codes **99358** and **99359** are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Code **99358** is used to report the first hour of prolonged service on a given date regardless of the place of service. It should only be used once per date.

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

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

<u>Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services</u>

- Specific instructions have been provided for reporting services when two providers of different groups are caring for a neonate or pediatric patient who requires intensive or critical care and the patient improves and is transferred to a lower level of care.
    - When a critically ill neonate or pediatric patient improves and is transferred to a lower level of care, the transferring physician reports subsequent hospital care (**99231-99233**) or hourly critical care services (**99291-992**92) as appropriate based on the condition of the neonate or child. The receiving physician reports subsequent intensive care (**99478-99480**) or subsequent hospital care (**99231-99233**) services as appropriate.
    - When an infant requiring subsequent intensive care services improves and is transferred to a lower level of care, the transferring physician reports subsequent hospital care (**99231-99233**).
- Specific instructions have been provided for reporting services when two providers of different groups are caring for a patient who becomes critically ill.
    - When a neonate or infant becomes critically ill and is transferred to a different physician, the transferring physician reports critical care services performed using hourly critical care codes (**99291-99292**) or intensive care services performed, but not both. The receiving physician reports subsequent inpatient neonatal or pediatric critical care (**99469. 99472**).

<u>Medicine</u>

Immunization Administration for Vaccine/Toxoids

►Report vaccine immunization administration codes **90460, 90461, 90471-90474** in addition to the vaccine and toxoid code(s) **90476-90749.**

►Report codes **90460** and **90461** only when the physician or qualified health care professional provides face-to-face counseling of the patient/family during the administration of a vaccine. For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family or for administration of vaccines to patients over 18 years of age, report codes **90471-90474.**

▲90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

▲90461 each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure.)

Vaccines/Toxoids

- CPT clarifies that multivalent antigens or multiple serotypes of antigens against a single organism are considered a single component vaccine.
- CPT codes **90470** (administration of H1N1 vaccine) and **90663** (influenza virus vaccine, pandemic formulation, H1N1) have been deleted. The H1N1 vaccine is no longer available.
- Editorial changes have been made to **90581** and **90664** to reflect the precise components and method of administration.
- New code **90654** has been added to describe a new formulation of influenza vaccine that will be administered intradermally

▲90851 Anthrax vaccine, for subcutaneous or intramuscular use

▲90644 Meningococcal conjugate vaccine, serogroups C & Y and *Haemophilus influenza*e B vaccine (Hib-MenCY), 4-dose schedule, when administered to children 2-15 months of age, for intramuscular use.

●90654 Influenza virus vaccine, split virus, preservative –free, for intradermal use

Special Otorhinolaryngologic Services

Audiologic Function Tests

A new code set is available to report automated evoked otoacoustic emissions, and codes **92587** and **92588** are revised.

●92558 Evoked otoacoustic emissions; screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis.

▲92587 Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report.

▲92588 Comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report.

Pulmonary

- A new section has been developed to identify pulmonary diagnostic testing and therapies.
- The introduction for codes **94010-94799** (pulmonary diagnostic testing and therapies) has been expanded to include specific directions for the use of the codes and what services are included within certain codes. For example, the introduction clarifies that spirometry (**94010** and **94060**) includes maximal breathing capacity (**94200**) and flow-volume loop (**94375**) when performed.
- CPT codes **94240-94370, 94720,** and **94725** have been deleted and replace with new codes **94726-94729**.

*(For additional revisions to reporting instructions and codes, please see the 2012 CPT book.)

Pulmonary Diagnostic Testing and Therapies

New codes have been introduced in Current Procedural Terminology (CPT) 2012 to report car seat/bed testing for airway integrity in the neonate.

●94780 Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, hear rate, and respiratory rate, with interpretation and report; 60 minutes

(Do not report **94780** for less than 60 minutes.)

●94781 each additional full 30 minutes
(List separately in addition to code for primary procedure.)

(Use **94781** in conjunction with **94780**.)

***(**For additional reporting instructions, please see the 2012 CPT book.)

Central nervous system Assessments/Tests
(eg, Neurocognitive, Mental Status, Speech Testing)

- The descriptor for code 96110 has changed from developmental **testing** to developmental **screening** and includes a revision to clarify that the service is reported per interpretation and report of each standardized instrument form.
- Code 96111 is revised to delete the word “extended”.

▲96110 Developmental screening, with interpretation and report, per standardized instrument form.

▲96111 Developmental testing (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration

- The infusion service guidelines are revised to clarify reporting multiple infusions, injections, or combinations and the intent and use of hydration and infusion codes.
- Instructions now state that codes **96360-96379**, **96401, 96402, 96409-96425**, and **96521-96523** are not to be reported by a physician when services are performed in a facility.
- An editorial revision has been made to code **96367** stipulating that the code is used in conjunction with codes **96365, 96374, 96409, or 9641**3 when the infusion of a *new drug or substance* is provided as a secondary or subsequent service after a different initial service is administered through the same intravenous (IV) access.
- Instructions specify that a minimum duration of 31 minutes of hydration infusion is required to report **96360**.
- Codes **96360-96379, 96401, 96402, 96409-96425, 96521-96523** are not intended to be reported by the physician in the facility setting. If a significant, separately identifiable office or other outpatient E/M service is performed, the appropriate E/M service (**99201-99215, 99241-99245, and 99354-99355**) should be reported using modifier **25** in addition to **96360-96549.** For same day E/M service, a different diagnosis is not required.

*(For additional revisions to reporting instructions and codes please see the 2012 CPT book.)

This is not an all-inclusive list of the 2012 CPT coding changes. Be sure to order your new 2012 CPT Coding Manual where a complete list of all coding changes can be found!