

## CPT Pediatric Coding Updates 2008

The 2008 *Current Procedural Terminology* (CPT) codes are effective as of January 1, 2008.

### Deletions

**36540** – collection of blood specimen from a completely implantable venous access device

**99361**- medical team conference 30 min

**99362**- medical team conference 60 min

**99371**- telephone call brief

**99372**- telephone call intermediate

**99373**- telephone call complex

### Revisions

#### Pediatric Critical Care Patient Transport

**99289, 99290** - bundled service 36540 (collection of blood specimen from a completely implantable venous access site) has been deleted and replaced with new code **36591**

#### Critical Care Services

**99291, 99292** – bundled service 36540 (collection of blood specimen from a completely implantable venous access site) has been deleted and replaced with new code **36591**

#### Inpatient Neonatal and Pediatric Critical Care and Intensive Services

**99293-99296, 99298-99300** – To report initial services to the neonate who is not critically ill, but requires intensive observation, frequent interventions, and other intensive care services, report code **99477**. Although the services are typically provided in a neonatal intensive care or special care unit, they may be performed in any inpatient hospital setting as long as the nursing expertise and monitoring equipment that are appropriate to provide the care are available 24 hours a day. When a neonate or infant requires continued intensive observation, frequent interventions, and other intensive care services, the existing Continuing Intensive Care Services codes (**99298-99300**) should be used to report services for those neonates/infants with present body weight of 5,000 g or less. When the present body weight of those neonates/infants exceeds 5,000 g, the Subsequent Hospital Care Services codes (**99231-99233**) should be used.

(For the initiation of inpatient care of the normal newborn, report **99431**.)

(For the initiation of care of the critically ill neonate, use **99295**.)

(For the initiation of inpatient hospital care of the neonate not requiring intensive observation, frequent interventions, and other intensive care services, see **99221-99223**.)

The pediatric and neonatal critical care codes are also bundled codes and include those procedures listed above for the hourly critical care codes (**99291, 99292**). In addition, the following procedures are also included in the bundled (global) pediatric and neonatal critical care service codes (**99293-99296**) and the initial and continuing intensive care codes (**99298-99300, 99477**): umbilical venous (**36510**) and umbilical arterial catheters (**36660**); other arterial catheters (**36140, 36620**); central (**36555**) or peripheral vessel catheterization (**36000**); vascular access procedures (**36400, 36405, 36406**); vascular punctures (**36420, 36600**); oral or nasogastric tube placement (**43752**); endotracheal intubation (**31500**); lumbar puncture (**62270**); suprapubic bladder aspiration (**51000**); bladder catheterization (**51701, 51702**); ventilatory management (**94002-94004**); continuous positive airway pressure (**94660**); surfactant administration (**94610**); intravascular fluid administration (**90760-90761**); transfusion of blood components (**36430, 36440**); invasive or noninvasive electronic monitoring of vital signs, bedside pulmonary function testing (**94375**); and/or monitoring or interpretation of blood gases or oxygen saturation (**94760-94762**). Any services performed that are not listed above should be reported separately.

### **Nursing Facility Services, New and Established Patients**

Codes **99304-99310** and **99318** have been revised to include the assignment of an average or typical time. These services may now be reported when more than 50% of the face-to-face encounter (physician to patient or family/caregiver) is spent in counseling and/or coordination of care or when the required key components (history, exam, medical decision-making) are met.

#### **Initial Nursing Facility Care**

- 99304** - Physicians typically spend 25 minutes with the patient and/or family or caregiver
- 99305** - Physicians typically spend 35 minutes with the patient and/or family or caregiver
- 99306** - Physicians typically spend 45 minutes with the patient and/or family or caregiver

#### **Subsequent Nursing Facility Care**

- 99307** - Physicians typically spend 10 minutes with the patient and/or family or caregiver
- 99308** - Physicians typically spend 15 minutes with the patient and/or family or caregiver
- 99309** - Physicians typically spend 25 minutes with the patient and/or family or caregiver
- 99310** - Physicians typically spend 35 minutes with the patient and/or family or caregiver

#### **Annual Nursing Facility Assessment**

- 99318** - Physicians typically spend 30 minutes with the patient and/or family or caregiver

### **Preventive Medicine Services**

**Counseling Risk Factor Reduction** – Revised Instructions/Revised Subheading under Preventive Medicine

**99401-99404** – These codes are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. They are distinct from E/M services that may be reported separately when performed. Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment.

Preventive medicine counseling and risk factor reduction interventions will vary with age and should address such issues as family problems, diet and exercise, substance abuse, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter.

For counseling groups of patients with symptoms or established illness, use **99078**.

**CPT Modifiers** – Descriptors of the following modifiers have been revised.

**22 – Increased Procedural Services** – When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier **22** to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

**51 – Multiple Procedures** – When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier **51** to the additional procedure or services code(s). **Note:** This modifier should not be appended to designated “add-on” codes (see Appendix D).

**58 – Staged or Related Procedure or Service by the Same Physician During the Postoperative Period** – It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier **58** to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition) see modifier **78**.

**59 – Distinct Procedural Service** – Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier **59** is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier **59**. Only if no more descriptive modifier is available, and the use of modifier **59** best

explains the circumstances, should modifier **59** be used. Note: Modifier **59** should not be appended to an E/M service. To report separate and distinct E/M service with a non-E/M service performed on the same date, see modifier **25**.

**76 – Repeat Procedure or Service by Same Physician** – It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier **76** to the repeated procedure/service.

**78 – Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period** - It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier **78** to the related procedure. (For repeat procedures, see modifier **76**.)

## New Codes

### Other Central Venous Access Procedures

Code **36540** has been deleted and replaced with new code **36591**.

**36591** – Collection of blood specimen from a completely implantable venous access device

**36593** – Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified

(Do not report **36591** or **36593** with any other service.)

### Case Management Service Codes

#### **Medical Team Conference, Direct (Face-to-Face) Contact With Patient and/or Family**

**99366** – Medical team conference with interdisciplinary team of health care professionals, face-to-face with the patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional

*(For team conference services by a physician with patient and/or family present, see Evaluation and Management services.)*

## **Medial Team Conference, Without Direct (Face-to-Face) Contact With Patient and/or Family**

**99367** – Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by the physician

**99368** – Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by non-physician qualified health care professional

*(Team conference services of less than 30 minutes duration are not reported separately.)*

### **Notes:**

No more than one individual from the same specialty may report 99366-99368 at the same encounter.

Individuals should not report 99366-99368 when their participation in the medical team conference is part of a facility or organizational service contractually provided by the organizational or facility provider.

The team conference starts at the beginning of the review of an individual patient and ends at the conclusion of the review. Time related to record keeping and report generation is not reported. The reporting participant shall be present for all time reported. The time reported is not limited to the time that the participant is communicating to the other team members or patient and/or family. Time reported for medical team conferences may not be used in the determination of time for other services such as care plan oversight (**99374-99380**); home domiciliary, or rest home care plan oversight (**99339-99340**); prolonged services (**99354-99359**); psychotherapy; or any E/M service.

When E/M services are performed separate from the team conference, the appropriate E/M service may be reported with modifier **25**.

### **Preventive Medicine Services**

**Behavior Change Intervention** - Revised subheading under Preventive Medicine Services/New Codes

**99406** – Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

**99407** – Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

(Do not report **99407** in conjunction with **99406**.)

**99408** – Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; 15 to 30 minutes

(Do not report services of less than 15 minutes with **99408**.)

**99409** – Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST, and brief intervention (SBI) services; greater than 30 minutes

(Do not report **99409** in conjunction with **99408**.)

(Do not report **99408**, **99409** in conjunction with **99420**.)

(Use **99408**, **99409** only for initial screening and brief intervention.)

### **Non-Face-to-Face Physician Services – Telephone Management and Online Medical Evaluation**

#### **Telephone Services**

The old codes used to report telephone calls, **99371-99373**, have been deleted and replaced with new codes **99441- 99443**.

**99441** – Telephone E/M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

**99442** – 11-20 minutes of discussion

**99443** – 21-30 minutes of discussion

#### **Online Medical Evaluation**

The new code **99444** for online medical evaluation has replaced the Category III code **0074T**.

**99444** – Online E/M service provided by a physician to an established patient, parent, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network

### **Non-Face-to-Face Non-physician Services** - New subsection in Medicine Section

#### **Telephone Services – (Nonphysician)**

**98966** – Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

**98967** - 11-20 minutes of medical discussion

**98968** - 21-30 minutes of medical discussion

## **Online Medical Evaluation – (Non-physician)**

**98969** – Online assessment and management service provided by a qualified non-physician health care professional to an established patient, guardian, or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network

## **Other Evaluation and Management Services**

### **Initial Neonatal Intensive Care Services**

**99477** – Initial hospital care, per day, for the E/M of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services

## **Category II Codes**

None of the new codes involve reporting performance measures on children with asthma.

**0001F-0012F** – Composite Measures

**0500F-0509F** – Patient Management

**1000F-1111F** – Patient History

**2000F-2031F** – Physical Examination

**3006F-3210F** – Diagnostic/Screening Process or Results

**4000F-4124F** – Therapeutic, Preventive, or Other Interventions

**5005F-5015F** – Follow-up or Other Outcomes

**6005F-6020F** – Patient Safety

**8P** – Performance measure reporting modifier – action not performed, not otherwise specified.

Modifier **8P** is intended to be used as a “reporting modifier” to allow the reporting of circumstances when an action described in a measure’s numerator is not performed and the reason is not otherwise specified.

*This is not an all inclusive list of the 2008 CPT coding changes. Be sure to order your new 2008 CPT Coding Manual where a complete list of all coding changes can be found!*