

CPT Pediatric Coding Updates 2010

The 2010 *Current Procedural Terminology* (CPT) codes are effective as of January 1, 2010.

NEW CODES

Trachea and Bronchi Endoscopy

- 31626** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed with placement of fiducial markers, single or multiple
- +31627** with computer-assisted, image-guided navigation
(List separately in addition to code for primary procedure[s])

Pathology

- 83987** pH; exhaled breath condensate

Immunization Administration for Vaccines/Toxoids

- 90470** H1N1 immunization administration (intramuscular, intranasal), including counseling when performed

Vaccines/Toxoids

- 90670** Pneumococcal conjugate vaccine, 13 valent, for intramuscular use

Pulmonary

- 94011** Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age
- 94012** Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age
- 94013** Measurement of lung volumes (ie, functional residual capacity [FRC], force vital capacity [FVC], and expiratory reserve [ERV] in an infant or child through 2 years of age

REVISED CODES

Instructions for Use of CPT

Unlisted Procedure or Service

The instructions for using unlisted codes for procedures or services has been changed to indicate that when an unlisted procedure or service is performed, either an unlisted CPT code should be reported or alternatively another appropriate code that may be found in other code sets may be reported.

- Check CPT Category III codes for new and emerging technology for the procedure or service performed.
- Check for a HCPCS (Healthcare Common Procedure Coding System) code for the procedure or service.
- Use unlisted CPT code when neither code set has an appropriate code

Note: Some payers may not recognize HCPCS codes so be sure to check payers' policies.

Guidelines

Special Reports

The guidelines for special reports have been revised to suggest the type of information that may be necessary to report new or unusual services.

A service that is rarely provided, unusual, variable, or new may require a special report. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service.

Evaluation and Management Services

Guidelines

New CPT language expands its definition of concurrent care and clearly differentiates concurrent care from transfer of care:

Concurrent care is the provision of similar services (eg, hospital visits) to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required.

Transfer of care is the process whereby a physician who is providing management for some/all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility, and who from the initial encounter, is not providing consultative services. The physician transferring care is then no longer providing care for these problems, though may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial

evaluation, but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

Consultations

Revisions have been made to the introductory language to be consistent with the new language defining concurrent care and transfer of care. The new language clearly states that a physician may report a consultation when it is requested by another physician or other appropriate source for recommendations of care or to determine whether to accept ongoing responsibility for care of the patient.

A consultation is a type of evaluation and management service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition/problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition/problem.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial inpatient care or initial nursing facility care.

Office or Other Outpatient Consultations (99241-99245)

The following codes are used to report consultations provided in the physician's office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, or emergency department (see the preceding consultation definition above). Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant or patient are reported using the appropriate codes for established patients, office visits (99211-99215), domiciliary, rest home (99334-99337), or home (99347-99350). If an additional request for an opinion or advice regarding the same or a new problem is received from another physician or other appropriate source and documented in the medical record, the office consultation codes may be used again. Services that constitute transfer of care (ie, are provided for the management of the patient's entire care or for the care of a specific condition or problem) are reported with the appropriate new or established patient codes for office or other outpatient visits, domiciliary, rest home services, or home services.

Inpatient Consultations (99251-99255)

The following codes are used to report physician consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting. Only one consultation should be reported by a consultant per admission. Subsequent services during the same admission are reported using subsequent hospital care codes (**99231-99233**) or subsequent nursing facility care codes (**99307-99310**), including services to complete the initial consultation, monitor progress, revise recommendations, or address a new problem. Use subsequent hospital

care codes (**99231-99233**) or subsequent nursing facility care codes (**99307-99310**) to report transfer of care services (see Concurrent Care and Transfer of Care definitions).

When an inpatient consultation is performed on a date that a patient is admitted to a hospital or nursing facility, all evaluation and management services provided by the consultant related to the admission are reported with the inpatient consultation service code (**99251-99255**). If a patient is admitted after an outpatient consultation (office, emergency department, etc), and the patient is not seen on the unit on the date of admission, only report the outpatient consultation code (**99241-99245**). If the patient is seen by the consultant on the unit on the date of admission, report all evaluation and management services provided by the consultant related to the admission with either the inpatient consultation code (99251-99255) or with the initial inpatient admission service code (**99221-99223**). Do not report both an outpatient consultation and inpatient consultation for services related to the same inpatient stay. When transfer of care services are provided on a date subsequent to the outpatient consultation, use the subsequent hospital care codes (**99231-99233**) or subsequent nursing facility care codes (**99307-99310**).

Prolonged Service Without Direct (Face-to-Face) Patient Contact

The instructions for prolonged service codes **99358** and **99359** have been revised to allow prolonged services without direct patient contact to be reported on a different date than the related primary service. Code **99358** is no longer considered an add-on code. The related or primary service may be any level E/M service, with or without an assigned average time, or a non E/M service.

Codes 99358 and 99359 are used when a physician provides prolonged service not involving direct (face-to-face) care that is beyond the usual non-face-to-face component of physician service time.

This service is to be reported in relation to other physician services, including evaluation and management 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 evaluation and management service performed earlier and commences upon receipt of past records. However, it must relate to a service or patient where direct (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 on a given date providing prolonged service, even if the time spent by the physician 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 be used only once per date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Code 99359 is used to report each additional 30 minutes beyond the first hour regardless of the place of service. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Do not report 99358 and 99359 for time spent in medical team conferences, on-line medical evaluations, care plan oversight services, anticoagulation management, or other non-face-to-face services that have more specific codes and no upper time limit in the CPT code set. Codes 99358-99359 may be reported when related to other non-face-to-face services codes that have a published maximum time (eg, telephone services).

Initial and Subsequent Nursing Facility Care (99304-99310, 99318)

The code descriptors for initial and subsequent nursing facility care have been revised to exclude the phrase “with the patient and/or family or caregiver”. The language “at the bedside and on the patient’s facility floor or unit with the patient and/or family or caregiver” remains.

The descriptors have been changed as follows for each of the codes in this family:

“Usually, the problem(s) requiring admission are of xx severity. Physicians typically spend xx minutes with the patient and/or family or caregiver at the bedside and on the patient’s facility floor or unit with the patient and/or family or caregiver.”

Surgery

Integumentary System

There are major changes in the Integumentary system, Skin, Subcutaneous, and Accessory Structures section of CPT. CPT has established specific definitions for debridement and excision. These revised definitions are located in the Integumentary and Musculoskeletal sections.

Musculoskeletal System

Extensive changes including new and revised codes and parenthetical and instructional notes addressing the placement of re-sequenced (out of numerical sequence) codes have been made. The changes can be found throughout each anatomical subsection (ie, head and neck, shoulder, forearm and wrist, hand and fingers, foot and toes).

Respiratory System

The following endoscopic procedure codes have been revised under the Trachea and Bronchi section: **31622-31625, 31628, 31641, 31643, 31645, 31646** and **31656**.

Vascular Injection Procedures

36120 Introduction of needle or intracatheter; retrograde brachial artery
36140 extremity artery

(**36145** has been deleted. To report see **36147** and **36418**.)

36147 Introduction of needle or catheter, AV shunt created for dialysis (graft/fistula); initial access with complete radiologic evaluation of dialysis access, including fluoroscopy, image documentation, and report (includes access of shunt, injection [s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava).

Pathology and Laboratory

83986 pH; body fluid, not otherwise specified

(For blood pH, see **82800, 82803**.)

Medicine

Immune Globulins, Serum or Recombinant Products

The introductory language has changed to incorporate serum and recombinant products.

Codes **90281-90399** identify the serum globulins, extracted from human blood; or recombinant immune globulin products created in a laboratory through genetic modification of human and/or animal proteins. Both are reported in addition to the administration codes **96365-96368, 96372, 96374, and 96375** as appropriate. Modifier **51** should not be reported with this section of products codes when performed with another procedure. The serum or recombinant globulin products listed here include broad-spectrum anti-infective immune globulins, antitoxins, various isoantibodies, and monoclonal antibodies.

The descriptor for code **90378** is revised, and code **90379** has been deleted because the product is no longer manufactured or available.

90378 Respiratory syncytial virus immune globulin (RSV-IgIM), monoclonal antibody, recombinant, for intramuscular use, 50 mg, each

Vaccines, Toxoids (90476-90749)

The introductory language guidelines of the Vaccines, Toxoids, section are changed to indicate that the term preservative-free (as defined in CPT codes **90655-90656**, and **90662**) includes products that contain very little or no preservatives at all. Also, the language stipulates that the age descriptions included in the CPT vaccine codes are not intended to identify a product's licensed age indication. Therefore, physicians should refer to the product's prescribing information prior to administration of a vaccine.

The "when administered to" age descriptions included in CPT vaccine codes are not intended to identify a product's licensed age indication. The term "preservative –free" includes use for vaccines that contain no preservative and vaccines that contain trace amounts of preservative agents that are not present in a sufficient concentration for the purpose of preserving the final vaccine formulation. The absence of a designation regarding a preservative does not necessarily indicate the presence or absence of preservative in the vaccine. Refer to the products prescribing information (PI) for the licensed age indication before administering vaccine to a patient.

Code **90669** has a revised descriptor, and a new vaccine product code for a pending 13-valent pneumococcal conjugate vaccine has been added. Note that code **90760** is awaiting US Food and Drug Administration approval.

90669 Pneumococcal conjugate vaccine, 7 valent, for intramuscular use
90670 Pneumococcal conjugate vaccine, 13 valent, for intramuscular use

Code **90644** was accepted by the CPT Editorial Panel for inclusion in the 2011 CPT manual. The code will not appear in CPT 2010. However, code **90644** is effective for reporting services on or after January 1, 2010, once it is approved by the FDA.

90644 Meningococcal conjugate vaccine, serogroups C and Y and Haemophilus influenzae type B vaccine, tetanus toxoid conjugate (Hib-MenCY-TT), 4 dose schedule, when administered to children 2 to 15 months of age, for intramuscular use

Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration (96360-96549)

The introductory paragraphs are revised to more clearly specify the reporting hierarchy for

physicians and facilities.

In order to determine which service should be reported as the initial service when there is more than one type of service, hierarchies have been created. These vary by whether the physician or a facility is reporting. The order of selection for physicians is based upon the physician knowledge of the clinical condition(s) and treatment(s). The hierarchy that facilities are to use is based upon a structural algorithm. When these codes are reported by the physician, the “initial” code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur.

When these codes are reported, *by the facility*, the following instructions apply. The initial code should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services which are primary to the hydration services. Infusions are primary to pushes, which are primary to injections. This hierarchy is to be followed by facilities and supersedes parenthetical instructions for add-on codes that suggest an add-on of a higher hierarchical position may be reported in conjunction with a base code of a lower position.

Category II Codes: 2 New Performance Measurements Applicable to Pediatrics

Category II codes have been developed for 2 new performance measures that apply to pediatric patients. See new Category II Codes in the 2010 CPT book.

Pediatric End-Stage Renal Disease

The pediatric ESRD (P-ESRD) measure is used during each calendar month that a patient aged 17 years and younger with a diagnosis of ESRD receiving hemodialysis has clearance of urea/volume (Kt/V) measurements as per the criteria listed in the codes below, has received an influenza vaccine, and has a plan of care documented. This new measure uses most of the same codes that were established for the ESRD measure. Separate measures for pediatric patients were developed because of the difference in the patient population and in the plan of care for pediatric patients.

HIV/AIDS

The HIV/AIDS measure will be reported by the physician providing ongoing HIV care. There is a new measure for Pneumocystis jiroveci pneumonia (PCP) prophylaxis in children 1 through 5 years of age, PCP prophylaxis in infants 6 weeks or older to younger than 12 months, and adolescent patients with HIV/AIDS who are prescribe potent antiretroviral therapy.

DELETED CODES

- 36145** arteriovenous shunt created for dialysis (cannula, fistula, or graft)
90379 Respiratory syncytial virus immune globulin (RSV-IgIM), human, for intramuscular use

This is not an all inclusive list of the 2010 CPT coding changes. Be sure to order your new 2010 CPT Coding Manual where a complete list of all coding changes can be found!