

CPT Pediatric Coding Updates 2015

The 2015 *Current Procedural Terminology* (CPT) codes are effective as of January 1, 2015. This is not an all-inclusive list of 2015 changes. TNAAP has listed below the codes we believe are of most interest to general pediatricians.

- ▶◀ - **New or Revised Text**
- + - **Add-on Code**
- - **New Code**
- ▲ - **Revised Code**
- # - **Out of Numeric Sequence**
- ⚡ - **FDA Approval Pending**

New and Revised Language

Evaluation and Management Services

Social History

- ▶ An age appropriate review of past and current activities that includes significant information about:
 - Marital status and/or living arrangements
 - Current employment
 - Occupational history
 - Military history
 - Use of drugs, alcohol, and tobacco
 - Level of education
 - Sexual history
 - Other relevant social factors ◀

Inpatient Neonatal and Pediatric Critical Care (99468-99469)

► Codes **99468, 99469** are used to report the services of directing the inpatient care of a critically ill neonate or infant 28 days of age or younger. They represent care starting with the date of admission (99468) to a critical care unit and subsequent day(s) (99469) that the neonate remains critical. These codes may be reported only by a single individual and only once per day, per patient, per hospital stay in a given facility. If readmitted to the neonatal critical care unit during the same day or stay, report the subsequent day(s) code 99469 for the first day or readmission to critical care, and 99469 for each day of critical care following readmission. ◀

► For initiation of selective head or total body hypothermia in the critically ill neonate, report 99184. ◀

(Codes 99481 and 99482 have been deleted.)

New and Revised Codes

Evaluation and Management Services

Care Management Services (99487, 99489 and 99490)

The Complex Chronic Care Coordination section has been retitled **Care Management Services**. This new section now represents two levels of Chronic Care Management – **Chronic Care Management Services** and **Complex Chronic Care Management Services**.

► Care management services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services may include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychological needs, and activities of daily living.

A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community/social services ordered, how the services of agencies and specialists unconnected to the practice will be

directed/coordinated, identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan.

Codes 99487, 99489, 99490 are reported only once per calendar month and may only be reported by the single physician or other qualified health care professional who assumes the care management role with a particular patient for the calendar month.

The face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professional, and agencies; revising, documenting, and implementing the care plan; or teaching self-management is used in determining the care management clinical staff time for the month. Only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient. Do not count any clinical staff time on a day when the physician or qualified health care professional reports an E/M service.

Care management activities performed by clinical staff typically include:

- Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care
- Communication with home health agencies and other community services utilized by the patient
- Collection of health outcomes data and registry documentation
- Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living
- Assessment and support for treatment regimen adherence and medication management
- Identification of available community and health resources
- Facilitating access to care and services needed by the patient and/or family
- Management of care transitions not reported as part of transitional care management (99495, 99496)
- Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service, noted above
- Development, communication, and maintenance of a comprehensive care plan

The care management office/practice must have the following capabilities:

- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week
- Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
- Provide timely access and management for follow-up after an emergency department visit or facility discharge

- Utilize an electronic health record system so that care providers have timely access to clinical information
- Use a standardized methodology to identify patients who require care management services
- Have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
- Use a form and format in the medical record that is standardized within the practice
- Be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient

E/M services may be reported separately by the same physician or other qualified health care professional during the same calendar month depending upon the E/M service provided.

If care management resumes after discharge during a new month, start a new period or report transitional care management services (99495, 99496) as appropriate. If discharge occurs in the same month, continue the reporting period or report Transitional Care Management Services. Do not report 99487, 99489, 99490 for any post-discharge care management services for any days within 30 days of discharge, if reporting 99495, 99496. ◀

Chronic Care Management Services

▶ Chronic care management services are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Code 99490 is reported when, during the calendar month, at least 20 minutes of clinical staff time is spent in care management activities ◀

●**#99490** Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- Comprehensive care plan established, implemented, revised, or monitored

▶(Chronic care management services of less than 20 minutes duration, in a calendar month are not reported separately.) ◀

Complex Chronic Care Management Services

► Complex chronic care management services are provided during a calendar month that includes criteria for chronic care management services as well as establishment or substantial revision of a comprehensive care plan; medical, functional, and/or psychosocial problems requiring medical decision making of moderate or high complexity; and clinical staff care management services for at least 60 minutes, under the direction of a physician or other qualified health care professional. Physicians or other qualified health care professionals may not report complex chronic care management services if the care plan is unchanged or requires minimal change (eg, only a medication is changed or an adjustment in a treatment modality is ordered). Medical decision making as defined in the Evaluation and Management (E/M) guidelines is determined by the problems addressed by the reporting individual during the month.

Patients who require complex chronic care management services may be identified by practice-specific or other published algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for caregiver, and/or repeat admissions or emergency department visits. Typical adult patients who receive complex chronic care management services are treated with three or more prescription medications and may be receiving other types of therapeutic interventions (eg, physical therapy, occupational therapy). Typical pediatric patients receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy). All patients have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Typical patients have complex diseases and morbidities and, as a result, demonstrate one or more of the following:

- Need for the coordination of a number of specialties and services
- Inability to perform activities of daily living and/or cognitive impairment resulting in poor adherence to the treatment plan without substantial assistance from a caregiver
- Psychiatric and other medical comorbidities (eg, dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care; and/or
- Social support requirements or difficulty with access to care ◀

- ▲ **99487** Complex Chronic Care Management services, with the following required elements:
- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
 - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
 - Establishment or substantial revision of a comprehensive care plan;
 - Moderate or high complexity medical decision making;
 - 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

► (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately.) ◀

► (99488 has been deleted. To report one or more face-to-face visits by the physician or other qualified health care professional that are performed in the same month as 99487, use the appropriate E/M code. ◀

▲+99489 Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for primary procedure)

► (Report 99489 in conjunction with 99487) ◀

► (Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex chronic care management services during a calendar month.) ◀

Advance Care Planning (99497-99498)

► Codes 99497 and 99498 are used to report the face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

(When using codes 99497, 99498, no active management of the problem(s) is undertaken during the time period reported.) ◀

●99497 Including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other health care professional, first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.

●+99498 Each additional 30 minutes. (List separately in addition to code for primary procedure)

► (Use code 99498 in conjunction with 99497) ◀

Central Nervous System Assessments/Tests (eg, Neuro-Cognitive, Mental Status, Speech Testing) (96110 and 96127)

▲ **96110** Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument.

▶ (For an emotional/behavioral assessment use code 96127) ◀

● **96127** Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument.

▶ (For developmental screening, use 96110) ◀

Medicine

Vaccines/Toxoids (90630, 90651, 90654, 90721, 90723, and 90734)

These codes identify the vaccine product only. To report the administration of a vaccine/toxoid, the vaccine/toxoid product code must be used in addition to an immunization administration code(s) 90460, 90461, 90471, 90472, 90473, 90474.

▶ Separate codes are available for combination vaccines (eg, DTP-Hib, DTap-Hib, HepB-Hib). It is inappropriate to code each component of a combination vaccine separately. If a specific vaccine code is not available, the unlisted procedure code should be reported, until a new code becomes available.

The vaccine/toxoid abbreviations listed in codes 90476-90748 reflect the most recent US vaccine abbreviations reference used in the Advisory Committee on Immunization Practices (ACIP) recommendations at the time of CPT code set publication. Interim updates to vaccine code descriptors will be made following abbreviation approval by the ACIP on a timely basis via the AMA CPT website (www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-i-vaccine-codes.page) The accuracy of the ACIP vaccine abbreviation designations in the CPT code set does not affect the validity of the vaccine code and its reporting function. ◀

#● **90630** Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative-free, for intradermal use

● **90651** Human Papillomavirus vaccine types 6,11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use

- ▲90654 Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use
- ▲90721 Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP/Hib), for intramuscular use
- ▲90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use
- ▲90734 Meningococcal conjugate vaccine, serogroups A, C, Y, and W-135, quadrivalent, for intramuscular use

Other Services and Procedures

- 99184 Initiation of selective head or total body hypothermia in the critically ill neonate, includes appropriate patient selection by review of clinical, imaging and laboratory data, confirmation of esophageal temperature probe location, evaluation of amplitude EEG, supervision of controlled hypothermia, and assessment of patient tolerance of cooling.

► (Do not report 99184 more than once per hospital stay) ◀

(99185 and 99186 have been deleted)

- 99188 Application of topical fluoride varnish by a physician or other qualified health care Professional

NOTE: Providers participating in the TennCare Dental Screening and Fluoride Varnish Program through DentaQuest will continue to report D-codes. Some commercial health plans may accept the new CPT code 99188 for fluoride varnish application. Be sure to check with payers.

Resources:

American Academy of Pediatrics, AAP Pediatric Coding Newsletter, October 2014
 American Medical Association, CPT Changes: An Insider's View 2015
 American Medical Association, CPT 2015