

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP)

CPT Pediatric Coding Updates 2014

The 2014 *Current Procedural Terminology* (CPT) codes are effective as of January 1, 2014. This is not an all inclusive list of the 2014 changes. TNAAP has listed below the codes we believe are of most interest to general pediatricians.

- ▶ - **New or Revised text**
- - **New code**
- ▲ - **Revised code**
- # - **Out of numeric sequence**
- ↷ - **FDA approval pending**

Revised Language

Evaluation and Management Services

Pediatric Critical Care Transport (#99485-99486)

▶ The following services are included when performed during the pediatric patient transport by the physician providing critical care and many not be reported separately; routine monitoring evaluations (eg, heart rate, respiratory rate, blood pressure, and pulse oximetry), the interpretation of cardiac output measurements (93562), chest X-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762) blood gases and information data stored in computers (eg, ECGs, blood pressures, hematologic data) (99090), gastric intubation (43752, 43753), temporary transcutaneous pacing (92953), ventilatory management (94002, 94003, 94660, 94662), and vascular access procedures (36000, 36400, 36405, 36406, 36415, 36591, 36600). Any services performed which are not list above should be reported separately.

▶ Code **99485** is used to report the first 30 minutes of non-face-to-face supervision of an interfacility transport of a critically ill or critically injured pediatric patient and should be reported only once per date of service. Only the communication time spent by the supervising physician with the specialty transport team members during an interfacility transport should be reported. Code 99486 is used to report each additional 30 minutes beyond the initial 30 minutes. Non-face-to-face interfacility transport of 15 minutes or less is not reported.

Complex Chronic Care Coordination Guidelines (99487-99489)

▶ These services typically involve clinical staff developing, substantially revising, and implementing a care plan under direction of the physician or other qualified health care professional. Substantial revision to a care plan typically occurs when the patient's clinical condition changes sufficiently (eg, identification of a new problem requiring additional

Complex Chronic Care Coordination Guidelines (99487-99489) - continued

interventions, introduction of new interventions because existing interventions are deemed ineffective, exacerbation of an existing problem requiring new interventions) to require more intensive staff monitoring, changes in the treatment regimen, and additional time to educate the patient and/or caregiver about the patient's condition and/or change in treatment plan and prognosis.

▶ Physicians or other health care professionals may not report care coordination 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).

▶ Patients who require complex chronic care coordination 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 a caregiver and/or repeat admissions or emergency department visits.

▶ Typical pediatric patients receive three or more therapeutic interventions (eg medications, nutritional support, respiratory therapy) and have two or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

▶ A care plan is based on a physical, mental, cognitive, social, functional, and environmental (re)assessment and an inventory of resources and supports. 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 patient will be directed/coordinated, identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan.

▶ The care coordination office/practice must have the following capabilities:

- provide 24/7 access to physicians or other qualified health care professionals or clinical staff;
- use a standardized methodology to identify patients who require chronic complex care coordination services;
- have an internal care coordination 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 providers, as appropriate for each patient.

Transitional Care Management Services (99495-99496)

► Codes **99495** and **99496** are used to report transitional care management (TCM) services. These services are for a new or established patient...

► TCM requires a face-to-face visit, initial patient contact, and medication reconciliation within specified time frames. The first face-to-face visit is part of the TCM service and not reported separately. Additional E/M services provided on subsequent dates after the first face-to-face visit may be reported separately.

► The same individual may report hospital or observation discharge services and TCM. However, the discharge service may not constitute the required face-to-face visit. The same individual should not report TCM services provided in the postoperative period of a service that the individual reported.

New Codes

Evaluation and Management/Non-Face-to-Face Services

Interprofessional Consultation (99446-99449)

The consultant should use the following codes to report interprofessional telephone/Internet consultations. An interprofessional telephone/Internet consultation is an assessment and management service in which a patient's treating (eg, attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician or other qualified health care professional in the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact with the consultant.

- 99446** Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified health care professional; 5-10 minutes of medical consultative discussion and review
- 99447** 11-20 minutes of medical consultative discussion and review
- 99448** 21-30 minutes of medical consultative discussion and review
- 99449** 31 minutes or more of medical consultative discussion and review

Evaluation and Management/Inpatient Neonatal and Pediatric Critical Care

Total Body Systemic or Selective Head Hypothermia

- #+99481** Total body systemic hypothermia in a critically ill neonate per day
- #+99482** Selective head hypothermia in a critically ill neonate per day

Medicine

Removal of Impacted Cerumen

- ▲ **69210** Removal of impacted cerumen, unilateral
- ▶ (For bilateral procedure, report 69210 with modifier 50)

Vaccines and Toxoids

- **90685** Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
- **90686** Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
- ↳ ● **90687** Influenza virus vaccine, quadrivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
- **90688** Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use

Evaluation of Speech, Language, and Hearing

- **92521** Evaluation of speech fluency (eg, stuttering, cluttering)
- **92522** Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);
- **92533** with evaluation of language comprehension and expression (eg, receptive and expressive language)
- **92524** Behavioral and qualitative analysis of voice and resonance

▶ Codes **92521**, **92522**, **92523**, and **92524** are used to report evaluation of speech production, receptive language, and expressive language abilities. Tests may examine speech sound production, articulatory movement or oral musculature, the patient's ability to understand the meaning and intent of written and verbal expressions, and the appropriate formulation and utterance of expressive thought.

Anogenital Examination

- ▲ **99170** Anogenital examination, magnified, in childhood for suspected trauma, including image recording when performed

Category III Codes

Automated Visual Evoked Potential

- 0333T** Visual evoked potential, screening of visual acuity, automated

This is not an all-inclusive list of the 2014 CPT coding changes. Be sure to order your new 2014 CPT Coding Manual where a complete list of all coding changes can be found!