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

CPT Pediatric Coding Updates 2013

The 2013 *Current Procedural Terminology* (CPT) codes are effective as of January 1, 2013. This is not an all inclusive list of the 2013 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**

New or Revised Language

Instructions for Use of the CPT Codebook

►Throughout the CPT code set the use of terms such as "physician," "qualified health care professional," or "individual" is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency).

Evaluation and Management (E/M) Services

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 physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional 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/other qualified health care professional or another physician/other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. (See Decision Tree for New vs Established Patients in the 2013 CPT book.)

In the instance where a physician/other qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician.

Hospital Observation or Inpatient Services (Including Admission and Discharge Services)

- Typical times have been established for observation or inpatient care services with same-day admission and discharge (**99234-99236**).
- The parenthetical listing of applicable codes following prolonged service code **99356** has been expanded to reflect use of code **99356** in conjunction with observation or inpatient hospital care service codes **99224-99226** and **99231-99236** (previously **99231-99233**).

Observation or Inpatient Hospital Care

▲99234 Typically, **40** minutes are spent at the bedside and on the patient's hospital floor or unit.

▲99235 Typically, **50** minutes are spent at the bedside and on the patient's hospital floor or unit.

▲99236 Typically, **55** minutes are spent at the bedside and on the patient's hospital floor or unit.

Pediatric Critical Care Patient Transport

▲99466 Critical care face-to-face services, during an interfacility transport of critically ill or injured pediatric patient, 24 months of age or younger; first 30-74 minutes of hands-on care during transport.

+▲99467 each additional 30 minutes (List separately in addition to code for primary service)

#●99485 Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes

+#●99486 each additional 30 minutes (List separately in addition to code for primary procedure)
(Use **99486** in conjunction with **99485**)

► (For physician direction of emergency medical systems supervision for a pediatric patient older than 24 months of age, or at any age if not critically ill or injured, use **99288**)

► (Do not report **99485, 99486** with any other services reported by the control physician for the same period)

► (Do not report **99485, 99486** in conjunction with **99466, 99467** when performed by the same physician)

*(For additional revisions to reporting instructions and guidelines, please see your 2013 CPT Book.)

Inpatient Neonatal and Pediatric Critical Care

- Guidelines for neonatal and pediatric critical care codes were revised to clarify reporting of codes **99468-99469** and **99471-99476.**
- Guidelines now instruct to report subsequent day neonatal critical care **99469** for the first day of readmission to critical care during a single hospital stay, and **99469** for each day of critical care following readmission.
- Codes **99471-99476** are described as direction of the inpatient care of a critically ill infant or young child from 29 days of postnatal age through less than 6 years of age.
- Report codes **99472** or **99476**, subsequent critical care of patients aged 29 days through younger than 6 years, for the first and subsequent days or readmission to critical care during a single hospital stay.
- New guidelines also address transfers from critical care to lower levels of care or lower levels to critical care with care at both levels by the same physician or a physician in the same group versus transfers between physicians of different groups.
- Guidelines now also address how transferring and receiving physicians report services when patients are transferred from one facility to another with care by physicians of the same or different specialty.

*(For additional revisions to reporting instructions and guidelines, please see your 2013 CPT Book.)

Inpatient and Continuing Intensive Care Services

- Guidelines for initial and continuing intensive care services have been revised in conjunction with the revisions to the guidelines for neonatal and pediatric critical care to clarify the use of codes **99477-99480** related to a transfer of care and in relation to other services provided on the same date.
- The revised guidelines address readmission to intensive care. Codes **99477-99480** may be reported only once per day and by a single individual physician per patient in a given facility. If the patient is readmitted to the intensive care unit during the same hospital stay, report subsequent day services **99478-99480** for the first day of intensive care and for each successive day that the child requires intensive care services.
- New guidelines also address transfers between intensive care and other levels of care on the same date with care at both level by the same physician or a physician in the same group versus transfers between physicians of different groups.

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<u>Complex Chronic Care Coordination Services</u>

►Complex chronic care coordination services are patient-centered management and support services provided by physicians, other qualified health care professionals, and clinical staff to an individual who resides at home or in a domiciliary, rest home, or assisted living facility. These services typically involve clinical staff implementing a care plan directed by the physician or

other qualified health care professional. These services address the coordination of care by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living.

Patients who require complex chronic care coordination services may be identified by algorithms that utilize reported conditions and services (eg, predictive modeling risk score or repeat admissions or emergency department use) or by clinician judgment. Typical patients have 1 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. Because of the complex nature of their diseases and morbidities, these patients commonly require the coordination of a number of specialties and services.

These services include moderate- or high-complexity medical decision-making not only in reference to any face-to-face evaluation and management service but also in relation to the medical, functional, and psychosocial problems addressed within a calendar month. A plan of care should be documented and shared with the patient and/or caregiver.

Codes **99487-99489** are reported only **once** per calendar month and include all non-face-to-face complex chronic care coordination services and none or 1 face-to-face office or other outpatient, home, or domiciliary visit. Codes **99487-99489** may only be reported by the single physician or other qualified health care professional who assumes the care coordination role with a particular patient for the calendar month.

Code **99487** is reported when, during the calendar month, there is no face-to-face visit with the physician or other qualified health care professional and at least 31 minutes of clinical staff time is spent in care coordination activities. Code **99488** is reported when, during the calendar month, there is a face-to-face visit with the physician or other qualified health care professional and at least 31 minutes of clinical staff time is spent in care coordination activities.

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 professionals and agencies; revising, documenting and implementing the care plan; or teaching self-management is used in determining the complex chronic care coordination clinical staff time for the month. **Note:** Do not count any clinical staff time on the date of the first visit or on a day when the physician or other qualified health professional reports an E/M service (office or other outpatient services 99211-99215; domiciliary; rest home services 99334-99337; home services 99347-99350).

Care coordination activities performed by clinical staff may include:

- communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professional) 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/caretaker 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;
- development and maintenance of a comprehensive care plan

● **99487** Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

● **99488** first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month

●**+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)

If a face-to-face visit was provided during the month by the physician or other qualified health care professional, report **99488**. Additional E/M services beyond the first visit may be reported separately by the same physician or other qualified health care professional during the same month.

The following services are not separately reported when provided in a month when complex chronic care coordination services are reported:

- Care plan oversight (99339, 99340, 99374-99378)
- Prolonged service without direct patient contact (99358, 99359)
- Anticoagulant management (99363, 99364)
- Medical team conferences (99366-99368)
- Education and training (98960-98962, 99071, 99078)
- Telephone (98966-98968, 99441-99443)
- Online medical evaluation (98969, 99444)
- Preparation of special reports (99080)
- Analysis of data (99090, 99091)
- Transitional care management (99495, 99496)
- Medication therapy management (99605-99607)
- End stage renal disease (90951-90970)

*(For additional revisions to reporting instructions and guidelines, please see your 2013 CPT Book.)

Transitional Care Management Services

►Codes **99495** and **99496** are used to report transitional care management services (TCM). These services are for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an

inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living).

TCM is comprised of one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction. Only services involving moderate- or high-complexity medical decision-making (as defined for E/M service guidelines) provided to established patients are reported.

TCM begins on the date of discharge and continues for the next 29 days. These services require an initial interactive patient contact, a patient visit, and medication reconciliation within specified time frames.

1. Within 2 business days of discharge, an interactive contact with the patient or caregiver must take place. This contact can be face-to-face or by telephone or electronic means.
2. A face-to-face visit must take place within 7-14 calendar days following discharge depending on the complexity of the patient and code reported.
3. Medication reconciliation and management must take place no later than the date of the first face-to-face visit following discharge.

The first face-to-face visit is part of the TCM and not separately reported. Additional face-to-face visits within the 30-day period may be reported separately.

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- communication (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;
- patient and/or family/caretaker 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.

Non-face-to-face services provided by the physician or other qualified health care professional may include:

- obtaining and reviewing the discharge information (eg, discharge summary, as available, or continuity of care documents;
- reviewing need for or follow-up on pending diagnostic tests and treatments;
- interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
- education of patient, family, guardian, and/or caregiver;

- establishment or reestablishment of referrals and arranging for needed community services
- assistance in scheduling any required follow-up with community providers and services.

Documentation must include the timing of the initial post-discharge communication with the patient or caregivers, date of the face-to-face visit, and the complexity of medical decision making.

●**99495** – **Transitional Care Management Services** with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

●**99496 – Transitional Care Management Services** with the following required elements:

- Communication (direct contact, telephone, electronic)
- Medical decision making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

Medical decision making and the date of the first face-to-face visit are used to select and report the appropriate TCM code. For **99496**, the face-to-face visit must occur within 7 calendar days of the date of discharge, and medical decision making must be of high complexity. For **99495**, the face-to-face visit must occur within 14 calendar days of the date of discharge, and medical decision making must be of at least moderate complexity.

Type of Medical Decision Making	**Face-to-Face Visit within 7 days**	**Face-to-Face Visit within 8-14 days**
Moderate Complexity	99495	99495
High Complexity	99496	99495

The same physician may report discharge services of the preceding inpatient or observation stay and TCM as long as no postoperative global period applies. Only one individual may report these services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for a subsequent discharge(s) within 30 days.

*(For additional revisions to reporting instructions and guidelines, please see your 2013 CPT Book.)

Medicine

Vaccines/Toxoids

▲ **90655** Influenza virus vaccine, trivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use

▲**90656**	Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
▲**90657**	Influenza virus, trivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
▲**90658**	Influenza virus vaccine, trivalent, split virus, when administered to individuals 3 years and older, for intramuscular use
▲**90660**	Influenza virus vaccine, trivalent, live, for intranasal use
#●**90672**	Influenza virus vaccine, quadrivalent, live, for intranasal use

Codes **90685-90688** will be used to report quadrivalent influenza vaccines for intramuscular use pending FDA approval.

Psychiatry

Psychiatric services include diagnostic services, psychotherapy, and other services to an individual, family, or group. Patient condition, characteristics, or situational factors may require services described as being with interactive complexity. Services may be provided to a patient in crisis. Services are provided in all settings of care and psychiatry services codes are reported without regard to setting. Services may be provided by a physician or other qualified health care professional. Some psychiatry services may be reported with Evaluation and Management Services (**99201-99255, 99281-99285, 99304-99337**, or **99341-99350**) or other services when performed. Evaluation and Management Services (**99201-99285, 99304-99337**, or **99341-99350**) may be reported for treatment of psychiatric conditions, rather than using Psychiatry Services codes, when appropriate.

Interactive Complexity

Code **90785** is an add-on code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation (**90791, 90792**), psychotherapy (**90832, 90834, 90837**) psychotherapy when performed with an evaluation and management service (**90833, 90836, 90838, 99201-99255, 99304-99337,** or **99341-99350**), and group psychotherapy (**90853**).

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical patients are those who have third parties, such as parents, guardians, other family members, interpreters, language translators, agencies, court officers, or schools involved in their psychiatric care.

These factors are typically present with patients who:

- Have other individuals legally responsible for their care, such as minors or adults with guardians, or
- Request others to be involved in their care during the visit, such as adults accompanied by one or more participating family members or interpreter or language translator, or

- Require the involvement of other third parties, such as child welfare agencies, parole or probation officers, or schools.

+●90785 Interactive complexity (List separately in addition to the code for primary procedure)

(Use **90785** in conjunction with codes for diagnostic psychiatric evaluation [**90791** and **90792**], psychotherapy [**90832, 90834**, and **90837**], psychotherapy when performed with an evaluation and management service [**90833, 90836, 90838, 99201-99255-, 99304-99337**, and **99341-99350**], and group psychotherapy.)

(Do not report **90785** in conjunction with **90839, 90840**, or in conjunction with E/M services when no psychotherapy service is also reported.)

*(For additional revisions to reporting instructions and guidelines, please see your 2013 CPT Book.)

Psychiatric Diagnostic Procedures

●90791 Psychiatric diagnostic evaluation
●90792 Psychiatric diagnostic evaluation with medical services

(Do not report **90791** or **90792** in conjunction with **99201-99337, 99341-99350, 99366-99368**, **99401-99444**).

Psychotherapy

●90832 Psychotherapy, 30 minutes with patient and/or family member
+●90833 Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

(Use **90833** in conjunction with **99201-99255, 99304-99337,** and **99341-99350**.)

●90834 Psychotherapy, 45 minutes with patient and/or family member
+●90836 Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

(Use **90836** in conjunction with **99201-99255, 99304-99337,** and **99341-99350**.)

●90837 Psychotherapy, 60 minutes with patient and/or family member
+●90838 Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

(Use **90838** in conjunction with **99201-99255, 99304-99337,** and **99341-99350**.)

Other Psychotherapy

●**90839** Psychotherapy for crisis, first 60 minutes
+●**90840** each additional 30 minutes (List separately in addition to code for primary service

(Do not report **90839, 90840** in conjunction with **90791, 90792**, psychotherapy **codes 90832-90838** or other psychiatric services, or **90785-90899**)

Other Psychiatric Services or Procedures

+●90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)

When pharmacologic management is provided in addition to psychotherapy services by a physician or other qualified health care professional who can report E/M services, report the appropriate E/M service code (**99201-99255, 99281-99285, 99304-99337, 99341-99350**) and the appropriate psychotherapy service (**90833, 90836, 90838**). Time spent in pharmacologic management is not counted toward time spent in psychotherapy. Code **90862** has been deleted. When pharmacologic management is reported in addition to psychotherapy by health care professionals who **cannot** report E/M services, the new code **90863**, may be reported in conjunction with codes **90832, 90834**, and **90837** (psychotherapy without an E/M service.)

*(For additional revisions to reporting instructions and guidelines, please see your 2013 CPT Book.)

Allergy Testing

●**95017 -** Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests
●**95018 -** Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal) sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and reports, specify number of tests

(**95010** and **95015** have been deleted.)

Sleep Medicine Testing

▲**95808** Polysomnography; any age, sleep staging with 1-3 additional parameters attended by a technologist

▲95810	age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
▲95811	age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist
#●95782	younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist
#●95783	younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy yor bi-level ventilation, attended by a technologist

Other Procedures and Services

▲99174	Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral

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!