AAP Pediatric Coding Newsletter™

Proven coding guidance from the American Academy of Pediatrics

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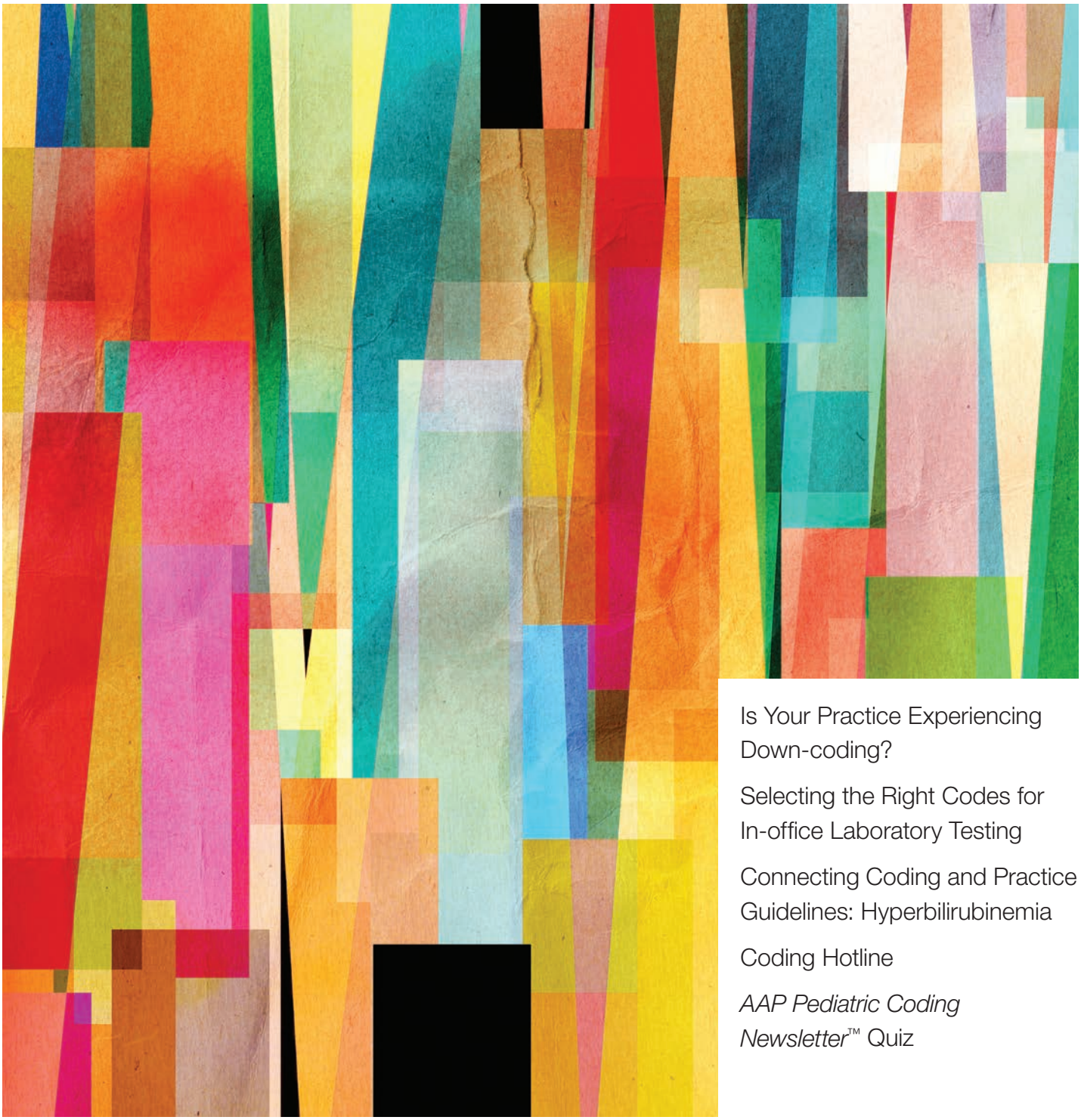
March 2023 | Volume 18 | Number 6



American Academy of Pediatrics

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AAP Pediatric Coding Newsletter™

Proven coding guidance from the American Academy of Pediatrics

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Vignettes are provided to illustrate correct coding applications and are not intended to offer advice on the practice of medicine.

Coding Symbols

▲ Revised code
● New code
+ Add-on code
↗ Product pending US Food and Drug Administration approval
Out-of-numerical-sequence code
★ Telemedicine
◂ Synchronous interactive audio

AAP Pediatric Coding Newsletter™ Volume 18, Number 6, ISSN 1934-5135 (Print), ISSN 1934-5143 (Online) is published monthly by the American Academy of Pediatrics, 345 Park Blvd, Itasca, IL 60143.

Periodicals postage paid at Arlington Heights, IL, and additional entries.

Postmaster: Send address changes to AAP Pediatric Coding Newsletter, American Academy of Pediatrics, Attn: Member and Customer Care, 345 Park Blvd, Itasca, IL 60143.

Subscriptions
Customer Service and Renewals: 888/227-1770
Renewals Online: **http://shop.aap.org/subscriptions**
For Secure Online Ordering: **https://shop.aap.org/aap-pediatric-coding-newsletter**
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Subscription Rates: Nonmember Rate: $250; Member Rate: $200. Save with a 2-year online and print subscription rate of $450 (nonmembers) or $360 (members).

Is Your Practice Experiencing Down-coding?

Article Highlights

How do you know if you have been affected by down-coding? What is your risk? This article will review some of the risk factors, signs and symptoms, and potential treatment of down-coding as outlined by the American Academy of Pediatrics (AAP) "Prepayment Downcoding Checklist" (https://downloads.aap.org/AAP/PDF/Downcoding%20Checklist.pdf).

- Down-coding policies affect payment for evaluation and management (E/M) services.
- The risk of down-coding is higher for some physicians and other qualified health care professionals (QHPs).
- Underpayment caused by down-coding may pass through the billing office unnoticed.
- Treatment of down-coding depends on the level of coding accuracy identified in chart reviews.

Down-coding happens when a physician or other QHP is paid based on a code for a lower level of service than was provided and supported in documentation. It has spread throughout health care and, if left undetected and unaddressed, can cause excessive revenue loss and increased administrative burdens.

Down-coding was once mostly caused by a physician's or QHP's choice to report lower-level E/M codes than what was supported by the documentation of the services (eg, reporting all established patient office E/M services with **99213**). A physician or QHP might down-code to avoid burdens associated with documenting and/or selecting the actual level of service provided, or in a belief that billing only mid-level services will avoid payer audits.

In recent years, down-coding has been increased by payer policy and payers' utilization of software to automatically pay for a lower level of service than what was reported.

Know Your Risk

Risk of down-coding is usually triggered by submission of E/M codes that represent the highest levels of service in a code category (eg, office or other E/M services) or subcategory (eg, new patient, office or other outpatient E/M services). Payer policies often target claims with level 4 and 5 codes for new or established patient office visits (**99204** and **99205** or **99214** and **99215**), outpatient consultations (**99244** and **99245**), or emergency department services (**99284** and **99285**).

If more than 50% of your E/M services are reported with the higher-level codes within the category of service reported, you are at higher risk of down-coding. For example, a physician reporting more than 50% of outpatient consultations with codes **99244** (moderate level of medical decision-making [MDM] or total time of ≥40 minutes) and **99245** (high level of MDM or total time of ≥55 minutes) may be at high risk of payer down-coding.

TIP

Physicians and QHPs who provide care to patients with medically complex conditions may be subjected to automated review of all their claims containing certain E/M service codes. This may result in down-coding and delayed payment. To be removed from this prepayment review program, the physician or QHP may need to submit a request for exemption from this program and include multiple records supporting consistently accurate code selection.

It is not appropriate or necessary to report codes for a lower level of service than what was clinically indicated, provided, and documented. In theory, the more physicians down-code their own claims, the more it might appear that physicians who are appropriately reporting are actually up-coding (ie, reporting a higher level of service than provided).

Signs and Symptoms of Down-coding

Underpayment caused by down-coding may pass through the billing office unnoticed. This may be especially true with automated payment posting, which is used in many billing systems. The billing office's attention may be focused on denied charges, allowing underpaid claims to go unchallenged. Early detection of down-coding may allow for preventive measures or recovery of lost revenue. Potential signs and symptoms of down-coding include the following:

- A payer publishes a news article or policy update that includes terms like "prepayment review" or "code review program."
- Payment that is lower than the agreed contractual/fee schedule rates, with or without notification that payment is for a reduced level of service (eg, when the reported code is unchanged on the remittance advice but the allowed amount is that of a lower level of service).
- A code for a lower level of service than that reported is included on the remittance advice.
- The payer includes claim adjustment reason codes and remark codes on the remittance advice that indicate down-coding. Examples of remittance advice remark codes that indicate down-coding include the following:

  CO150 Payer deems the information submitted does not support this level of service.

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M85 Subjected to review of physician evaluation and management services

- A noticeable increase in amounts adjusted off as non-allowed amounts (ie, not billable to the patient) and decreased revenue compared with the same period in a prior year.

TIP

Payer policies may specifically state that the code on the remittance advice will be the code that was reported on the claim even when a fee schedule amount for a lesser code will be paid based on automated prepayment edits. The down-coding may not be readily apparent.

Alerts in practice management or billing systems are useful for discovering down-coding and other reasons for payment at less than the contractual/fee schedule amount. Alternatively, practice management system reports of allowed amounts for higher-level E/M codes or specific remittance advice codes entered with payments may be manually reviewed on a regular basis.

Once symptoms of down-coding are recognized, it is important to identify the onset and scope of the problem. It is important to determine if the problem is limited to a single physician or other QHP or is systemic across the practice.

Treatment of Down-coding

Once down-coding is recognized, conduct a chart review to verify that the medical record documentation for each service subjected to down-coding supports the level of service reported. This may be conducted by internal staff or an independent coding consultant.

TIP

Focus chart reviews on the procedure code *and the diagnosis codes* reported. The first-listed diagnosis code should accurately reflect the condition chiefly responsible for the services provided and link to the procedure code on the claim.

Addressing this situation depends on the level of coding accuracy identified in chart reviews. If the procedure and diagnosis codes reported are not supported in the documentation, education to improve documentation and coding practices is indicated. It may also be appropriate to submit a corrected claim if the level of service was accurately reported but the diagnosis code(s) reported didn't accurately reflect the problem(s) addressed.

If, after chart review, the codes reported are found to be accurate, an appeal of the down-coding is appropriate. The AAP "Prepayment Downcoding Checklist" (https://downloads.aap.org/AAP/PDF/Downcoding%20Checklist.pdf) provides advice for developing a system for filing and tracking appeals and outcomes. Multiple levels of appeal are often required.

TIP

Appealing denied or down-coded claims is often a multistep process with initial appeals frequently denied.

It is also advisable to know your rights under payer contracts, state law and processes, and the Health Insurance Portability and Accountability Act Administrative Simplification Rule. These may affect how health plans use automated down-coding or otherwise change submitted codes and also offer an opportunity to challenge down-coding beyond appeal of individual claims.

Patterns of down-coding should be reported to the AAP Coding Hotline and Hassle Factor Form to help inform payer advocacy work (https://form.jotform.com/Subspecialty/aapcodinghotline).

Key Takeaways

This article has provided the following key points regarding down-coding.

- Down-coding has been increased in recent years by payer policy and payers' utilization of software to automatically pay for a lower level of service than what was reported.
- Early detection of down-coding may allow for preventive measures or recovery of lost revenue.
- The AAP "Prepayment Downcoding Checklist" (https://downloads.aap.org/AAP/PDF/Downcoding%20Checklist.pdf) provides advice for developing a system for filing and tracking appeals and outcomes.

Dig Deeper

Learn more about the consequences of down-coding and responding to down-coding in the *AAP News* article, "What to do if payers downcode pediatric visits" (https://publications.aap.org/aapnews/news/19862/What-to-do-if-payers-downcode-pediatric-visits).

The American Medical Association also has educational resources and an informational survey to track issues with down-coding by private payers (www.ama-assn.org/practice-management/claims-processing/tools-proper-payment-appeals).

Beyond Down-coding: Prepayment Review Policies for Modifier **25**

Every practice should have a process for maintaining awareness of payer notifications and policy changes. Physicians and other qualified health care professionals (QHPs) are often unaware of new payer policies and practices until revenue is lost. The following is an example of a policy that may result in erroneous denial of an evaluation and management (E/M) service when the E/M code is appended with modifier **25** (distinct, separately identifiable E/M service).

EXAMPLE

A registered nurse reviews the information on all claims submitted with modifier **25** (significant, separately identifiable E/M service) to determine whether it is likely that the modifier was correctly submitted. The nurse reviews the patient's claim history and the assigned diagnosis codes; if these do not appear to support modifier **25**, the E/M code is denied in this prepayment review. Denied claims may be appealed with submission of medical records.

Physicians and QHPs must be aware of the correct use of modifier **25** when reporting an E/M service on the same date as another service that has an E/M component (eg, minor surgical procedure). Documentation should clearly support the significant nature of the E/M service. Diagnosis codes assigned and linked to each service may provide support for the separate E/M service. However, neither *Current Procedural Terminology®* nor Medicare policy requires different diagnoses for E/M and other services when reporting modifier **25**.

When unaware of policies and processes such as the example noted previously, a billing office might change the codes or modifiers and resubmit the previously denied claim and then receive another denial. With limited time for appealing a denied claim, this puts the practice at greater risk of never receiving payment for claims on which modifier **25** was appropriately appended to an E/M code but for which the payer requires an appeal with submission of supporting documentation.

Contractual agreements between payers and physicians and/or QHPs may require that the payer provide notification prior to policy changes. However, these notifications are generally not personalized and are published in newsletters, online provider sites, or other methods that require active engagement on the part of the practice. Which member of your practice is paying attention to payer notifications?

Selecting the Right Codes for In-office Laboratory Testing

Article Highlights

This article reviews differences in code categories and reporting instructions for point-of-care laboratory testing, including the following:

- Clinical Laboratory Improvement Amendments (CLIA) status
- Codes by test type
- Coding for related services

Many practices perform select types of laboratory testing in the office (ie, point-of-care testing) while also sending samples for more complex testing to external laboratories. Multiple techniques (eg, enzyme-linked immunosorbent assay; detection by nucleic acid) may be available to test for a single pathogen, so code selection must accurately reflect the type of testing performed.

CLIA Status

All laboratories, including those within a physician practice, must comply with CLIA and must typically report a current CLIA certificate number on claims. The CLIA regulations establish quality standards for all laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test was performed. In a physician office or other outpatient clinic setting, point-of-care testing is usually limited to CLIA categories for waived tests and moderate-complexity testing.

TIP

A very small number of tests, such as an intradermal skin test for tuberculosis (**86580**) and total transcutaneous bilirubin (**88720**), are excluded from CLIA edits.

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The term *CLIA-waived* refers to simple laboratory examinations and procedures that have an insignificant risk of an erroneous result when manufacturer instructions are followed. Modifier **QW** (CLIA-waived test) may be required when reporting these tests because the same procedure code may represent tests that are CLIA-waived and tests of a higher complexity. Use of the **QW** modifier may vary by payer.

EXAMPLE	
87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique
	Or when reporting use of a CLIA-waived test and the payer requires use of the QW modifier
87636 QW	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique

TIP

A small number of CLIA-waived tests are exempt from the use of modifier **QW** (eg, **81002**, nonautomated urinalysis without microscopy, and **81025**, urine pregnancy test).

Moderate- and high-complexity tests are performed only by laboratories certified as meeting the CLIA quality system standards, such as those for proficiency testing, quality control and assessment, and personnel requirements. The difference between moderate- and high-complexity certification is the personnel required. No modifier is required to designate moderate or high complexity.

A limited list of moderate-complexity tests may be performed by a laboratory that holds a certificate for provider-performed microscopy (PPM). Tests that may be performed by a physician or QHP with a PPM certificate include urinalysis with microscopy, fern tests, and potassium hydroxide preparations.

Codes by Test Type

Code selection should focus on the type of testing platform used, the testing technique and sample type, and the purpose of the test (eg, infectious agent detection). Some tests provide qualitative results (eg, positive or negative), while others provide semiquantitative or quantitative results. Table 1 provides examples of point-of-care testing platforms, codes illustrating the technique used and purpose of the test, and related coding tips.

See codes **80047–80076** to report laboratory test panels (eg, basic metabolic panel).

Test manufacturers may provide coding advice, but correct codes should be verified by comparing the characteristics of the test performed to the code descriptor.

Table 2 provides examples of codes for tests that may be performed and reported in pediatric practice.

Coding for Related Services

Report collection of blood samples for testing (eg, venipuncture, **36400–36415**) in a physician practice regardless of whether the laboratory test is performed in the office or at an outside facility. Specimen collection (eg, nasal or oral swab, urine collection), other than blood sampling, is typically not separately reported.

Report office preparation of a specimen for transport to an outside laboratory with code **99000**.

Code **99072** may be reported for additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a public health emergency, as defined by law, due to respiratory-transmitted infectious disease. Payment for services reported with this code may vary based on payer policy.

When laboratory tests are ordered during an encounter, the order for each test is included in the amount and/or complexity of data to be reviewed and analyzed (even when the test is performed in-house). Remember that for purposes of counting the number of tests ordered and/or reviewed, when tests are represented by a single *Current Procedural Terminology*® code (as with **87428**, which describes a test for SARS-CoV, SARS-CoV-2, and influenza virus types A and B), this is considered 1 test ordered and/or reviewed.

Key Takeaways

When reporting point-of-care laboratory tests, consider the following in code selection.

- Multiple techniques (eg, enzyme-linked immunosorbent assay; detection by nucleic acid) may be available to test for a single pathogen, so code selection must accurately reflect the type of testing performed.
- Code selection should focus on the type of testing platform used, the testing technique and sample type, and the purpose of the test (eg, infectious agent detection).

Table 1. Types of Point-of-care Tests

Testing Platform	Technique, Sample, and Purpose	Tips
Qualitative dipstick or reagent method with visual interpretation	**81002** Urinalysis, *by dip stick or tablet reagent* for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; *non-automated, without microscopy*	This test is sometimes bundled to E/M services provided on the same date. However, some payers pay this code when modifier **25** is appended to the E/M service code.
Infectious agent with direct optical (ie, visual) observation (typically a test kit requiring no reading device or test analyzer)	**87807** IA with direct optical (ie, visual) observation; *RSV* **87804** IA with direct optical (ie, visual) observation; *influenza* **87811** IA with direct optical (ie, visual) observation; *SARS-CoV-2* **87880** IA with direct optical (ie, visual) observation; *Streptococcus A*	For a single test in this category that yields distinct results for each of multiple infectious agents, report a code for each result (eg, influenza A, **87804**; influenza B, **87804 59** [distinct procedure]; and SARS-CoV-2, **87811**).
Tests using an electronic analyzer or reading device	**85025** CBC, *automated*, with differential WBC count **87428** IA technique, qualitative or semiquantitative; *SARS-CoV, SARS-CoV-2 and influenza virus types A and B* **87636** Infectious agent detection *by nucleic acid (DNA or RNA); SARS-CoV-2 and influenza virus types A and B*, multiplex amplified probe technique	Report 1 unit of service with codes **87428**, **87636**, and **0241U** as testing for multiple infectious agents is included. (Use codes **87631–87633** when testing for other than SARS-CoV-2, influenza A/B, and RSV.) The most up-to-date PLA codes for detecting SARS-CoV-2 in addition to other pathogens are most easily found in *CPT®* Appendix O and quarterly updates posted to www.ama-assn.org/practice-management/cpt/cpt-pla-codes.
PLA	**0241U** Infectious disease (viral respiratory tract infection), *pathogen-specific RNA*, 4 targets (SARS-CoV-2, influenza A, influenza B, RSV), *upper respiratory specimen*, each pathogen reported as detected or not detected (Xpert Xpress SARS-CoV-2/Flu/RSV (all targets), Cepheid)	

Abbreviations: CBC, complete blood cell count; *CPT, Current Procedural Terminology;* E/M, evaluation and management; IA, infectious agent antigen detection by immunoassay; PLA, proprietary laboratory analysis; RSV, respiratory syncytial virus; WBC, white blood cell.

Table 2. Codes for CLIA-Waived Laboratory Tests Commonly Performed in Pediatric Practices

82247	Bilirubin, total
85013[a]	Blood count: spun hematocrit
85018	Blood count hemoglobin
82272[a]	Blood, occult, peroxidase activity qualitative feces, 1–3 specimens
82947	Glucose; quantitative, blood (except reagent strip)
82962[a]	Glucose blood by glucose monitoring device
86308	Heterophile antibodies screen
87804	Influenza, rapid, direct optical observation (When applicable, report with 1 unit per distinct result.)
87636	Influenza A and B and SARS-CoV-2 by nucleic acid (DNA or RNA) MAPT
87637	Influenza A and B, SARS-CoV-2, and RSV, by nucleic acid (DNA or RNA) MAPT
87807	RSV, rapid, direct optical observation
87635	SARS-CoV-2 by nucleic acid (DNA or RNA) MAPT
87430	Streptococcus group A, immunoassay technique, qualitative or semiquantitative
87880	Streptococcus group A, rapid, direct optical observation
81002[a]	Urinalysis nonautomated without scope

Abbreviations: CLIA, Clinical Laboratory Improvement Amendments; MAPT, multiplex amplified probe technique; RSV, respiratory syncytial virus.
[a] Modifier **QW** is not required for this test to be recognized as a CLIA-waived test.

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Connecting Coding and Practice Guidelines: Hyperbilirubinemia

Article Highlights

This article focuses on codes associated with pathological neonatal hyperbilirubinemia. This includes the following:

- Diagnosis codes associated with identifying risk factors for significant hyperbilirubinemia
- Assignment of codes for tests used in screening, diagnosis, and/or monitoring hyperbilirubinemia
- Documenting to support the level of evaluation and management (E/M) service provided

In August 2022, "Clinical Practice Guideline Revision: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation" was published in *Pediatrics* (https://doi.org/10.1542/peds.2022-058859). This AAP clinical practice guideline includes risk factors, tests, and procedures related to the diagnosis and management of hyperbilirubinemia.

Codes Associated With Identifying Risk Factors for Hyperbilirubinemia

Evaluation and monitoring for hyperbilirubinemia include identifying neonates with risk factors that require closer monitoring than neonates without risk factors for significant hyperbilirubinemia.

TIP

To report physiologic jaundice, report **P59.9**, neonatal jaundice, not otherwise specified. It is not appropriate to report code **E80.6** (other disorders of bilirubin metabolism) when reporting hyperbilirubinemia in a neonate. Newborn jaundice is reported with a code from categories **P55** or **P57–P59**.

The Table includes a list of risk factors for hyperbilirubinemia and associated *International Classification of Diseases, 10th Revision, Clinical Modification* (*ICD-10-CM*) codes or code categories that may be used to report each risk factor. Risk factors are reported when clinically significant (ie, require E/M or affect the E/M of other conditions).

Documentation of risk factors for significant hyperbilirubinemia may provide support for inpatient care, close follow-up after discharge, orders for durable medical equipment, and levels of E/M service required to determine and initiate the appropriate patient management. Codes for risk factors for neurotoxicity, such as neonatal sepsis (eg, **P36.0**, sepsis of newborn due to streptococcus, group B) or acute bilirubin encephalopathy due to isoimmunization (**P57.0**, kernicterus due to isoimmunization), are supportive of higher levels of E/M service.

TIP

The *ICD-10-CM* codes reported on a patient's claim are increasingly used to determine the appropriateness of the level of E/M service reported. Appropriately assigning and linking codes for the condition or signs and symptoms that were chiefly responsible for the service provided is important to support appropriate payment.

Codes for Bilirubin Testing

Multiple tests may be ordered and the results used in medical decision-making (MDM) for the neonate who is jaundiced. In addition to reporting codes for tests performed in a physician practice, the procedure codes for tests are used in determining the number of tests ordered and/or test results reviewed and analyzed when determining the level of MDM for E/M code selection (eg, initial hospital E/M services, **99221–99223**). For example, a complete blood cell count (CBC) includes multiple components but is represented by 1 *Current Procedural Terminology* (*CPT*®) code (eg, **85025**; description later in article) and is considered 1 test ordered or 1 test result reviewed.

The following are codes for some tests associated with E/M of jaundice and hyperbilirubinemia. Each test that is represented by a unique code is counted as 1 test ordered or, for tests ordered by a physician or other qualified health care professional of another specialty or another group practice, 1 result reviewed and analyzed. Multicomponent test panels reported with a single code, like the CBC, are considered single tests/single review of results.

86880	Antihuman globulin test (Coombs test); direct, each antiserum (direct antiglobulin test, DAT)
86900	Blood typing, serologic; ABO
86901	Blood typing, serologic; Rh (D)
82247	Total serum bilirubin
82248	Bilirubin; direct
88720	Bilirubin, total, transcutaneous
85025	Blood count: complete (CBC), automated (Hgb, RBC, WBC, and platelet count) and automated differential WBC count
82040	Albumin; serum, plasma, or whole blood
80051	Electrolyte panel (must include carbon dioxide (bicarbonate) **82374** , chloride **82435**, potassium **84132**, and sodium **84295**)

Codes for Reporting Risk Factors for Significant Hyperbilirubinemia

During the birth admission only, an attending physician or other QHP will report first a code for live-born infant (category **Z38**). All other physicians and QHPs will report first the condition chiefly responsible for the service provided and not report a code from category **Z38**. Codes from category **Z38** are not reported during a readmission after discharge from the birth admission.

Risk Factor	Diagnosis Code(s) (*ICD-10-CM*)
Down syndrome	**Q90.0** Trisomy 21, nonmosaicism **Q90.1** Trisomy 21, mosaicism **Q90.2** Trisomy 21, translocation **Q90.9** Down syndrome, unspecified
Exclusive breastfeeding with suboptimal intake	**P92.5** Neonatal difficulty in feeding at breast
Family history or genetic ancestry suggestive of inherited red blood cell disorders, including G6PD deficiency	**Z83.2** Family history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Hemolysis from any cause, if known or suspected based on a rapid rate of increase in the TSB or TcB of >0.3 mg/dL per hour in the first 24 hours or >0.2 mg/dL per hour thereafter	**P58.9** Neonatal jaundice due to excessive hemolysis, unspecified (Not reported in conjunction with codes for isoimmunization in categories **P55–P57**)
Jaundice in the first 24 hours after birth	**P59.9** Neonatal jaundice, unspecified **P55.0** Rh isoimmunization of newborn **P55.1** ABO isoimmunization of newborn
Lower gestational age (ie, risk increases with each additional week <40 weeks)	**P07.38–P07.39** Preterm newborn (35–36 completed weeks) **P59.0** Neonatal jaundice associated with preterm delivery (*ICD-10-CM* codes do not describe gestational age of >36 but <40 completed weeks.)
Macrosomic infant of a diabetic mother	**P70.0** Syndrome of infant of mother with gestational diabetes **P70.1** Syndrome of infant of a diabetic mother (Codes in category **P08**, disorders of newborn related to long gestation and high birth weight, *are not reported* in conjunction with codes **P70.0** and **P70.1**.)
Parent or sibling requiring phototherapy or exchange transfusion	**Z84.89** Family history of other specified conditions
Phototherapy before discharge	Code for hyperbilirubinemia or hemolysis or, if resolved at time of encounter, report **Z09** Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm **Z86.39** Personal history of other endocrine, nutritional and metabolic disease
Predischarge TcB or TSB concentration close to the phototherapy threshold	**P59.9** Neonatal jaundice, unspecified *Assign a code for more specifically identified jaundice when diagnosed.*
Scalp hematoma or significant bruising	**P12.0** Cephalhematoma due to birth injury **P12.1** Chignon (from vacuum extraction) due to birth injury **P12.3** Bruising of scalp due to birth injury **P03.2** Newborn affected by forceps delivery **P03.3** Newborn affected by delivery by vacuum extractor [ventouse]

Abbreviations: G6PD, glucose-6-phosphate dehydrogenase; *ICD-10-CM, International Classification of Diseases, 10th Revision, Clinical Modification;* QHP, qualified health care professional; TcB, transcutaneous bilirubin; TSB, total serum bilirubin.

Testing of transcutaneous bilirubin (TcB) or total serum bilirubin (TSB) may be ordered to test a neonate with hyperbilirubinemia neurotoxicity risk factors immediately, twice more at 4-hour intervals, and then 3 times at 12-hour intervals. The order for a series of a single test (represented by 1 *CPT* code) is counted once toward the amount and/or complexity of data to be reviewed and analyzed on that date. For each day of subsequent hospital care (**99231–99233**) after the date that the testing was ordered, the physician or QHP may include review of new test results in the amount and/or complexity of data to be reviewed and analyzed.

TIP

If a TSB is ordered in response to a concerning result from a TcB test performed at the same encounter, both tests are included in the amount and/or complexity of data to be reviewed and analyzed because each test is represented by a unique *CPT* code.

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Documenting to Support Evaluation and Management of Hyperbilirubinemia

Care provided to a newborn with hyperbilirubinemia may range from outpatient office E/M services to inpatient hospital and neonatal intensive or critical care. The level of service reported will vary for each encounter based on the neonate's condition at the time of the encounter (eg, physiologic jaundice, recovering well or not adequately responding to phototherapy). Documentation should include findings of history, examination, and test results or other data reviewed, tests ordered, differential diagnoses considered, options considered and selected for further diagnostic workup or treatment (eg, home phototherapy versus hospitalization). Diagnoses should be documented for each condition addressed and the appropriate *ICD-10-CM* codes assigned to provide support for the level of service provided. The *ICD-10-CM* code that represents the condition or problem that was chiefly responsible for the services provided should be listed first in the assessment and plan and be the first code linked to the procedure code.

Key Takeaways

Coding for management of neonatal hyperbilirubinemia may involve a range of diagnosis and procedure codes. Appropriate documentation and code selection can affect prior authorization of services and payment.

- Documentation of risk factors for significant hyperbilirubinemia may provide support for inpatient care, close follow-up after discharge, orders for durable medical equipment, and levels of E/M service required to determine and initiate the appropriate patient management.
- Appropriately assigning and linking codes for the condition or signs and symptoms that were chiefly responsible for the service provided is important to support appropriate payment.

Online Exclusive

Visit https://publications.aap.org/codingnews to access "You Code It! Management of Hyperbilirubinemia" to test your skills at assigning diagnosis and procedure codes for care of the neonate with hyperbilirubinemia. Answers to the challenge, and the reasoning behind each answer, are also included online.

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- Report collection of blood samples for testing (eg, venipuncture, **36400–36415**) in a physician practice regardless of whether the laboratory test is performed in the office or at an outside facility.

Dig Deeper

See Chapter 12, "Common Non-facility Testing and Therapeutic Services," in *Coding for Pediatrics 2023* for additional information on coding for point-of-care testing.

For information specific to testing for COVID-19 (SARS-CoV-2), see the COVID-19 coding fact sheet at www.aap.org/en/practice-management/practice-financing/coding-and-valuation/coding-fact-sheets.

Resources for determining the categorization of tests include

- A list of CLIA-waived analytes provided by the US Food and Drug Administration (www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm)
- A list of PPM tests and procedure codes provided by the Centers for Medicare & Medicaid Services (www.cms.gov/regulations-and-guidance/legislation/clia/downloads/ppmplist.pdf)

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Coding Hotline

HCPCS: Nebulizer Supplies

Our practice is billing code A7005 to report the mask and tubing used when providing nebulizer treatments in the office, but these charges are denied. Is there another code for reporting the supplies used to provide nebulizer treatments?

Code **A7005** is used to report provision of an administration set for use with a small volume nonfiltered pneumatic nebulizer (typically for use in a patient's home). Code **A7003** is similarly used to report provision of a disposable administration set, and code **A7015** is used to report supply of an aerosol mask used with a durable medical equipment nebulizer. However, most payers have adopted some version of the Medicare Resource-Based Relative Value Scale (RBRVS), which assigns values to each component of a service. The 3 components are the physician's or other qualified health care professional's (QHP's) work, the practice expense of providing the service (eg, clinical staff time, supplies), and the professional liability expense. When payment is based on the RBRVS, typical supplies such as those reported with **A7005** are included in the practice expense value assigned to the code for the related service (eg, **94640**, pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device).

TIP

Payer policies often limit the frequency of payment for supplies like the nebulizer administration sets. If a physician office reports a code for a nebulizer supply kit for in-office treatment and the charge is paid, the patient's benefit for nebulizer supplies may be exhausted for a time (eg, 1 month; 3 months).

Learn More About Payment Based on RBRVS

See the American Academy of Pediatrics "Code Valuation and Payment RBRVS" website (www.aap.org/en/practice-management/practice-financing/coding-and-valuation/code-valuation-and-payment-rbrvs) to learn more about the RBRVS and how it affects payment for pediatric services.

ICD-10-CM: Diagnostic Results

When an in-office laboratory test is performed and the result is documented, should the diagnosis code linked to the laboratory test code be a code for the symptoms that prompted the test or for the diagnosis to which the test result contributed?

When the physician or other QHP has interpreted the test result and a final diagnosis is available at the time of coding, any confirmed or definitive diagnosis(es) should be reported in lieu of signs and symptoms. For example, a patient with complaint of illness including a sore throat is tested for streptococcal pharyngitis. Based on a positive test result and examination findings, a diagnosis of streptococcal pharyngitis is documented. The diagnosis code linked to the codes for the test and the office visit are **J02.0** (streptococcal pharyngitis). If the test result was negative and the diagnosis was acute pharyngitis, code **J02.9** (acute pharyngitis, unspecified) would be linked to the codes for the test and the office visit. Only report codes for signs and symptoms when no definitive diagnosis is documented or the signs and symptoms are not routinely associated with the diagnosed condition.

Got a coding question? Submit it to the experts at the AAP Coding Hotline at **https://form.jotform.com/Subspecialty/aapcodinghotline**.

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0.5 Continuing Education Units

1. **Which of the following is most likely to raise your risk of prepayment claim review and down-coding?**
   a. More than 50% of your evaluation and management (E/M) services are reported with the higher-level codes.
   b. You seldom, if ever, report E/M service codes.
   c. You select codes based on medical decision-making (MDM).
   d. You select codes based on total time spent on the day of the encounter.

2. **True or false? Physician office laboratories must comply with Clinical Laboratory Improvement Amendments.**
   a. True
   b. False

3. **Which of the following includes the expense of supplies typically used to provide a service in the value assigned to that service?**
   a. *Current Procedural Terminology*®
   b. Healthcare Common Procedure Coding System
   c. *International Classification of Diseases, 10th Revision, Clinical Modification*
   d. Medicare Resource-Based Relative Value Scale

4. **When determining the amount and/or complexity of data to be reviewed and analyzed, how many tests are counted for an order or review of results of a complete blood cell count?**
   a. 5 (hemoglobin, hematocrit, red blood cells, white blood cells, and platelet count)
   b. Either 5 or 6 depending on whether a differential white blood cell count is included
   c. 1
   d. 1 or 2 depending on whether a differential white blood cell count is included

5. **Which of the following is true of reporting diagnoses for laboratory testing services?**
   a. Always report only the symptoms that prompted the order for testing.
   b. Always report the diagnosis code for a suspected condition that prompted an order for testing.
   c. Report the code for signs and symptoms when a physician or qualified health care professional has not documented a definitive diagnosis.
   d. Report codes for a definitive diagnosis and for any signs and symptoms that prompted an order for testing.