AAP Pediatric Coding Newsletter™

Proven coding guidance from the American Academy of Pediatrics

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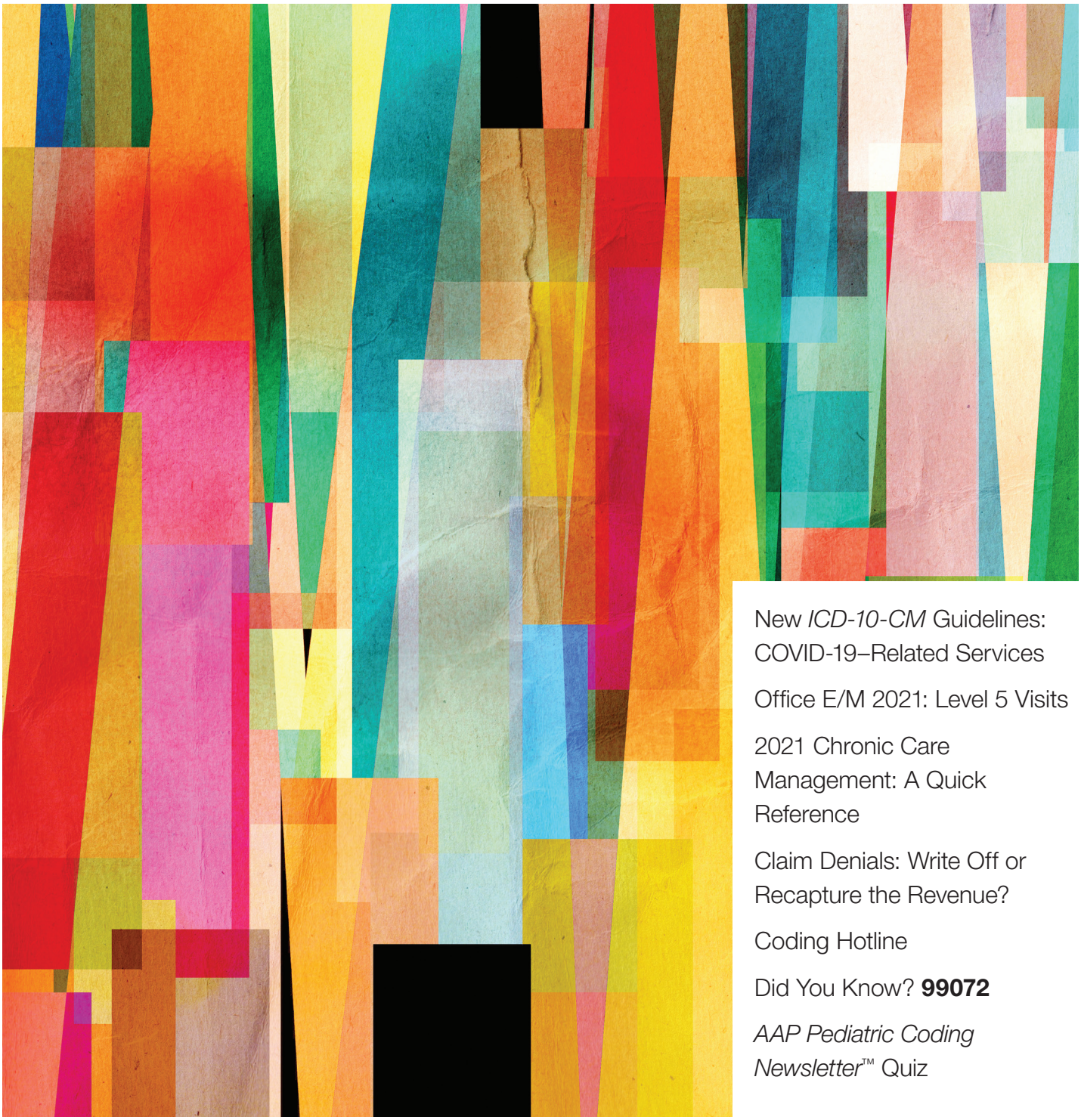

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

AAP Pediatric Coding Newsletter™

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CONTENTS

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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

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New *ICD-10-CM* Guidelines: COVID-19–Related Services

Recently released official guidelines support the correct use of *International Classification of Diseases, 10th Revision, Clinical Modification* (*ICD-10-CM*). These guidelines were implemented on October 1 for coding and reporting fiscal year 2021 (October 1, 2020–September 30, 2021). They provide new instructions for reporting diagnoses associated with coronavirus disease 2019 (COVID-19) testing and treatment. The following points from these guidelines support correct code assignment and accurate reporting for public health data:

COVID-19 Screening/Testing

The guidelines are clear that during the COVID-19 pandemic, *no encounter for testing should be considered screening* but should be coded as exposure or suspected exposure to COVID-19. This applies to all testing, including preoperative testing. The guidelines further indicate that guidance will be updated as new information and change in the pandemic status become available.

ICD-10-CM Contact/Exposure Codes

Category **Z20** codes are for patients who fall into 1 or both of the following 2 categories:

- Are suspected to have been exposed to a disease by close personal contact with an infected individual
- Are in an area where a disease is epidemic

Diagnosed COVID-19

All diagnosed cases of COVID-19, including asymptomatic patients who test positive, are reported with code **U07.1**. (See additional information on COVID-19 and newborns later in this article.)

U07.1 COVID-19

Code **U07.1** is reported when a physician's diagnostic statement confirms COVID-19 infection. A positive test result is not required when a physician diagnoses COVID-19 based on clinical judgment. Documentation of a positive test result for COVID-19 is also basis for assigning code **U07.1**. Do not assign **U07.1** when the documentation indicates uncertain or probable COVID-19 (ie, report codes for signs and symptoms and/or exposure).

Assign additional codes for any manifestations of the infection, such as

J12.89 Other viral pneumonia

J20.8 Acute bronchitis due to other specified organisms

J22 Unspecified acute lower respiratory infection

J80 Acute respiratory distress syndrome

J96.01 Acute respiratory failure with hypoxia

J96.02 Acute respiratory failure with hypercapnia

A08.39 Other viral enteritis

EXAMPLE

A new patient presents with suspected exposure to COVID-19 with symptoms of fever for 3 days and some coughing. A point-of-care test result for COVID-19 is positive. The patient's diagnosis is documented as COVID-19 with fever and mild respiratory symptoms. The pediatrician reports an office visit (eg, **99203**) and **87635 QW** (infectious agent detection by nucleic acid [DNA or RNA]; severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease (COVID-19)], amplified probe technique). Both **99203** and **87635 QW** are linked to code **U07.1** because COVID-19 infection was diagnosed at the encounter. Symptoms of fever and cough are not separately reported. (When diagnosed, an additional code for a manifestation, such as a lower respiratory infection, is reported.) Modifier **QW** indicates that the test reported with **87635** was a waived test under the Clinical Laboratory Improvement Amendments.

Coding for care of newborns who test positive for COVID-19 is dependent on whether documentation indicates the condition was contracted in utero or during the birth process, or not (ie, community-acquired). When there is no documentation of the specific type of transmission, report code **U07.1** and codes for the associated manifestations in neonates. If the documentation specifies that the virus was contracted in utero or during the birth process, assign codes **P35.8** and **U07.1**. The newborn's attending physician will list first the appropriate code from category **Z38** (liveborn infant, according to place of birth and type of delivery).

P35.8 Other congenital viral diseases

Newborn COVID-19 Suspected or Ruled Out

When a newborn's mother is known to be positive for COVID-19 but the status of the baby is unknown, report code **P00.2** (newborn affected by maternal infectious and parasitic diseases).

If, during the hospital stay, the baby is tested and COVID infection is ruled out, report **Z05.1** (observation and evaluation of newborn for suspected infectious condition ruled out) instead of **P00.2**.

...continued on page 4

...continued from page 3

EXAMPLES

1. A newborn whose mother is mildly ill with COVID-19 tests positive. The attending physician's diagnosis is asymptomatic congenital COVID-19 infection. Codes **P35.8** and **U07.1** are reported in addition to **Z38.00** (single liveborn infant, delivered vaginally).
2. A newborn, whose mother tested positive for COVID-19 at delivery but who was no longer symptomatic at the time of delivery, presents for outpatient follow-up care and tests positive for COVID-19 on day 7 after the newborn's birth. The diagnosis is COVID-19 infection, undetermined whether acquired during the birth process or community-acquired. Code **U07.1** and codes for manifestations of COVID-19 are reported.

COVID-19 Negative or Undiagnosed

Report code **Z20.828** for known or suspected exposure to COVID-19 without a confirmed diagnosis at the time of the encounter.

Z20.828 Contact with and (suspected) exposure to other viral communicable diseases

When asymptomatic patients are tested and not determined to have COVID-19 at the time of the encounter, code **Z20.828** is reported as the first or only code for the encounter/testing.

When patients are symptomatic but the infection is ruled out or not confirmed at the encounter (ie, no definitive diagnosis of COVID-19 or positive test result is documented), code **Z20.828** may be reported in addition to codes for the patient's symptoms (eg, **R05**, cough; **R50.9**, fever, unspecified).

EXAMPLES

1. A patient who was exposed to a person who later tested positive for COVID-19 presents for testing due to diarrhea and stomach pain. The test result for COVID-19 is negative. The pediatrician diagnoses viral gastroenteritis with exposure to COVID-19. Diagnoses reported are **A08.4** (viral intestinal infection, unspecified) and **Z20.828**.
2. A 17-year-old patient who recently returned to his mother's home after visiting his father in another state requests COVID-19 testing due to a school policy that requires either a negative test result or 14-day quarantine after out-of-state travel. The test result is negative, and the diagnosis code reported is **Z20.828**.
3. A child presents with cough and gastrointestinal symptoms in an area where a previously high incidence of COVID-19 infections has been dropping for 2 weeks. Tests for influenza and COVID-19 are performed with a positive result for influenza A. The COVID-19 test is sent to an outside laboratory and results are not available at the encounter. The pediatrician reports **J10.2** (influenza due to other identified influenza virus with gastrointestinal manifestations) linked to the service lines for the office visit and influenza test, and code **Z20.828** is linked to the codes for the office visit and test for COVID-19.

Personal History and Follow-up After COVID-19

Personal history of COVID-19 is reported with code **Z86.19**. Code **Z09** is assigned when patients who have recovered from COVID-19 infection are seen in follow-up. List **Z09** first, followed by **Z86.19**, when reporting.

Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Z86.19 Personal history of other infectious and parasitic diseases

Reporting History Codes

History codes are acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

EXAMPLES

1. A child who was previously diagnosed with COVID-19 presents for follow-up 7 days after discharge from the hospital. The child's parents report infrequent coughing and improved activity and appetite. COVID-19 test results are negative. The pediatrician reports **Z09** and **Z86.19**.
2. A child who recovered from COVID-19 infection with pneumonia 3 months earlier reports with a runny nose, cough, and fever. The pediatrician diagnoses an upper respiratory infection with history of COVID-19. Codes **J06.9** (acute upper respiratory infection, unspecified) and **Z86.19** (personal history of other infectious and parasitic diseases) are reported.

Encounter for COVID-19 Antibody Testing

Report code **Z01.84** when antibody testing for COVID-19 antibodies is performed *except* when the test is performed to confirm a current COVID-19 infection (report a code based on the diagnosis known at the time of the encounter) or when a follow-up test is performed after resolution of COVID-19 infection (report **Z09** and **Z86.19**).

EXAMPLE

A child who had mild symptoms of COVID-19 two weeks earlier is seen for fatigue. The parent reports that the child was not tested for COVID-19 at the time of illness due to the lack of severe symptoms. There was no known exposure to COVID-19 prior to the onset of symptoms. The pediatrician orders a COVID-19

...continued on page 7

Office E/M 2021: Level 5 Visits

This article provides information and examples of the changes that will be implemented for office and other outpatient evaluation and management (E/M) codes provided on or after January 1, 2021. Previous articles in this series, which began in the January 2020 *AAP Pediatric Coding Newsletter*™, have addressed

- The reason for the changes (ie, simplification of code selection and reduction of documentation burden)
- A basic overview of what is changing (ie, code selection based on medical decision-making [MDM] or on a physician's or qualified health care professional's [QHP's] total time on the day of service)
- More in-depth reviews of the use of time and MDM, including each element of MDM
- Nonphysician E/M visits (**99211**)
- Level 2–4 visits

E/M 2021: DIVE DEEPER ONLINE

To view all *AAP Pediatric Coding Newsletter* content related to E/M 2021, visit https://coding.aap.org and click on "Coding Resources."

Please note that information provided in this article is based on the instructions published by the American Medical Association at the time of publication. Changes or corrections may occur prior to official release of *Current Procedural Terminology* (*CPT*®) *2021.*

In this issue, we explore example scenarios that might be reported with codes at level 5 of the office E/M services (**99205** and **99215**) for dates of service on and after January 1, 2021.

★▲**99205** **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 60–74 minutes of total time is spent on the date of the encounter.

(For services 75 minutes or longer, see Prolonged Services **99417**)

★▲**99215** **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 40–54 minutes of total time is spent on the date of the encounter.

(For services 55 minutes or longer, see Prolonged Services **99417**)

As previously noted, for each level of office E/M service, the MDM is the same for new or established patients. For level 5 codes selected based on MDM, 2 of 3 elements must be met or exceeded to support a high level of MDM.

Table 1 shows the elements of MDM to support high-complexity MDM.

Table 1. High-Complexity Medical Decision-making

	Medical Decision-making (2 of 3 required: problems, data, risk)[a]		
Level/Codes	**Problems Addressed**	**Data Reviewed and Analyzed**	**Risk (examples only)**
High New patient **99205** Established patient **99215**	**High**–1 of the following: • ≥1 chronic illness(es) with severe exacerbation, progression, or side effects of treatment *Asthma with respiratory distress* • 1 acute or chronic illness or injury that poses a threat to life or bodily function *Depression with suicidal ideation*	**Extensive** (Meet 2 of 3 categories.) **Category 1** (Meet any 3.) • Review of prior external note(s) from each unique source • Reviewing the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) **Category 2:** Independent interpretation of a test performed by another physician/other QHP **Category 3:** Discuss management or test interpretation with external physician/other QHP/appropriate source.	**High** • Drug therapy requiring intensive monitoring for toxicity *A physician monitors for toxicity due to long-term use of an antiepileptic drug.* • Decision regarding elective major surgery with identified patient or procedure risk factors *Decision for scoliosis repair in a patient with cerebral palsy and respiratory compromise* • Decision regarding emergency major surgery *Decision for surgery for appendicitis* • Decision regarding hospitalization *Decision for or against hospital admission in a patient who is in acute respiratory distress* • Decision not to resuscitate or to de-escalate care because of poor prognosis *Shared decision-making with a patient and family regarding treatment failure and decision for palliative care*

Abbreviation: QHP, qualified health care professional.

[a]Examples included in *italic* text are not included in *Current Procedural Terminology*® and are intended only to illustrate how the preceding bullet point might be met. The elements of medical decision-making (MDM) may vary across individual patient services, and code selection for each service should reflect the extent of MDM by the physician or other QHP.

...continued on page 6

...continued from page 5

TIP

A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. Monitoring for therapeutic effect is not equivalent to monitoring for toxicity or other adverse effect. Drug therapy requiring intensive monitoring for toxicity may be by a laboratory test, a physiologic test, or imaging. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient (eg, monitoring of ototoxicity via audiometry findings).

When selecting a code based on the physician's or QHP's total time spent directed to care of the individual patient, on the date of the encounter, 60 to 74 minutes is required to report **99205** and 40 to 54 minutes to support **99215**. Total time includes face-to-face and non–face-to-face time (eg, time spent entering information into the medical record) directed to the care of the individual patient on the date of a visit.

EXAMPLE: MDM FOR LEVEL 5 OFFICE E/M

A 6-year-old is seen by his primary care pediatrician due to his parents' concerns of recent bed-wetting and new complaints of abdominal pain. History obtained from the parents indicates that the child has been thirsty but not eating as usual for 2 days. Complaints of abdominal pain began the night before this visit. The child has lost 8 pounds since his last visit 2 months ago. After examination, urinalysis, and review of multiple laboratory findings (eg, blood glucose, blood gases, complete blood cell count, blood urea nitrogen with creatinine), the pediatrician diagnoses new onset type 1 diabetes with ketoacidosis and orders intravenous fluids and immediate hospitalization. The pediatrician calls a pediatric endocrinologist, who agrees to assume management of the patient in the hospital. Code **99215** is reported.

Table 2. Medical Decision-making for Level 5 Office Evaluation and Management

	Medical Decision-making (*2 of 3 required: problems, data, risk*)		
Level/ Codes	**Problems Addressed**	**Data Reviewed and Analyzed**	**Risk of Complications and/or Morbidity/ Mortality of Patient Management**
High Established patient **99215**	**High** 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** **Category 1** (*Meet any 3.*[a]) • Review of the result(s) of each unique test • Assessment requiring an independent historian(s) **Category 3:** Discuss management or test interpretation with external physician/ other QHP/appropriate source.	**High** • Decision regarding hospitalization

[a]Category 2 of the data reviewed and analyzed is the independent interpretation of a test performed by another physician/other QHP. Any 2 of 3 categories is sufficient to support an extensive amount and/or complexity of data reviewed and analyzed.

Each of the 3 elements of MDM support a level 5 service, though only 2 of 3 are required (Table 2). If the pediatrician in this example ordered the urinalysis and a comprehensive metabolic panel (**80053**) in lieu of multiple individual laboratory tests, the amount and complexity of data reviewed and analyzed would be moderate rather than extensive, but the problems addressed and risk of the management would still be high, supporting a level 5 visit.

TIP

A decision regarding hospitalization that results in a decision to not admit the patient but to closely monitor on an outpatient basis supports a high risk of complications and/or morbidity or mortality.

EXAMPLE: TIME-BASED CODE SELECTION

An 8-year-old patient is referred to a pediatrician for follow-up care after an observation stay that resulted in a new diagnosis of asthma. Prior to the visit, the pediatrician's clinical staff obtain health records from the hospital and a local health clinic where the child has received primary care, including immunizations, which were brought up to date at the beginning of the last school year.

At the visit, the child is accompanied by his paternal grandmother, who has been the only caregiver for the past 4 months. Whereabouts of the child's mother are unknown, and his father is deceased. The grandmother voices intent to become her grandchild's permanent guardian and requests education on asthma control and assistance in helping the child cope with grief. The grandmother also notes that the child attends a summer camp program 3 days of the week when she works. The staff of the summer camp have expressed concern that the child wanders away from activities if not constantly watched and is alternately withdrawn from and aggressive toward the other children and counselors.

After examination and reviewing the child's asthma control test, the pediatrician discusses and answers questions from the grandmother about asthma management, control medications, and quick relief medications. After a general psychosocial assessment tool is completed and scored, the physician talks briefly with the patient and then counsels the patient and grandmother about seeing a clinical social worker for counseling and assistance with access to community resources, as needed. The grandmother agrees to an appointment with the social worker. A follow-up appointment for recheck of asthma control is scheduled. The

physician's total time on the date of the visit is 65 minutes, including preservice record review, the face-to-face visit, and post-visit care coordination including writing a referral letter to the social worker, a prior authorization for counseling services, and documentation of the encounter. Code **99205** is reported based on time.

Had the patient in this example been established to the pediatrician, the total time of 65 minutes would support prolonged service in addition to code **99215**. One unit of prolonged service **99417** is reported for each full 15-minute period beyond the *minimum time* required to support the office E/M service. See Table 3 for time requirements for new and established patients. *CPT* does not place a limit on the number of units reported per encounter for code **99417**.

99417 Prolonged office or other outpatient evaluation and management service(s) (beyond the minimum required time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes

At the time of publication, *CPT* and the Centers for Medicare & Medicaid Services were in conflict with regard to when prolonged services (**99417**) begin. We have presented the timing from *CPT* as part of this newsletter. For more information or to check for a resolution, please visit www.aap.org/coding.

Code **99417** is reported only with codes **99205** and **99215** and *only when the office E/M code was selected based on time*.

Codes **99354** and **99355** (direct prolonged services in an outpatient setting) will no longer be reported for prolonged service on the date of an office E/M service provided in 2021.

Table 3. Time Requirements for Code 99417

Base Office E/M Code With Included Total Minutes	Total Minutes on the Date of the E/M Service and Units of Prolonged Service (includes only time spent by a physician or other QHP) (**99417** is added only when total time is the basis for reporting **99205** or **99215**.)
99205 60–74	<75: Do not report **99417**.
	75–89: **99205** and **99417** × 1
	90–104: **99205** and **99417** × 2
	≥105: **99205** or **99417** × 3 + 1 additional unit for each additional full 15 min
99215 40–54	<55: Do not report **99417**.
	55–69: **99215** and **99417** × 1
	70–84: **99215** and **99417** × 2
	≥85: **99215** and **99417** × 3 +1 additional unit for each additional full 15 min

Abbreviations: E/M, evaluation and management; QHP, qualified health care professional.

More to Come

As we draw closer to 2021, watch for additional information and examples in future issues of *AAP Pediatric Coding Newsletter*. You can also find more information on coding for office E/M services in Chapter 7 of *Coding for Pediatrics 2021* and *Pediatric Office-Based Evaluation and Management Coding: 2021 Revisions*.

New *ICD-10-CM* Guidelines: COVID-19–Related Services *...continued from page 4*

antibody test and documents diagnoses of fatigue and possible history of COVID-19 infection. Codes **R53.83** (other fatigue) and **Z01.84** are reported.

A code for a diagnosis documented as "possible" is not reported (ie, no code is reported for "possible history of COVID-19").

TIP

Only report 1 unit of service of **86328** (immunoassay for infectious agent antibody[ies], qualitative or semiquantitative, single step method [eg, reagent strip]; severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease (COVID-19)]) per reagent strip regardless of the number of antibodies evaluated (eg, IgG and IgM results on 1 strip equal 1 unit).

Beyond the Guidelines

Coding for multisystem inflammatory syndrome in children (MIS-C) due to COVID-19 was not included in the *ICD-10-CM* guidelines at the time of this publication. However, the following is guidance for reporting this condition with current infection or history of COVID-19 (eg, determined by antigen testing):

- If the patient with MIS-C has an active COVID-19 infection, report first code **U07.1** and add **M35.8** (other specified systemic involvement of connective tissue) as a secondary diagnosis for MIS-C due to COVID-19. MIS-C is a manifestation of the COVID-19 infection. (Coders should query physicians when it is unclear if the patient has a current COVID-19 infection versus a residual effect from previous infection.)
- When a patient who is not diagnosed with current COVID-19 infection is diagnosed with MIS-C due to COVID-19, report codes **M35.8** and **B94.8** (sequelae of other specified infectious and parasitic diseases) as a secondary diagnosis for the sequelae of a COVID-19 infection.

Remember, reporting codes for current or past infection with COVID-19 is based on the physician's diagnostic statement and not limited to documentation of test results.

2021 Chronic Care Management: A Quick Reference

Chronic care management (CCM) service codes and instructions for reporting these services have undergone refinements to more accurately identify the work and resources of these services since the initial CCM codes were added to *Current Procedural Terminology* (*CPT*®) in 2013. This continues in 2021 and additional refinements are likely in 2022. These refinements bring additional opportunities for pediatricians to gain payment for care management services. However, understanding the key differences in the services reported with each code for CCM services is important to correct coding and appropriate payment.

In 2021, the total time of service and type of clinician whose time was spent providing CCM services continue to be deciding factors in determining which codes (**99487**, **99489**, **99490**, **99439**, **99491**) are reported. *Note: **99439** is reported only for services provided on or after January 1, 2021.*

Complex Chronic Care Management

▲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,
- comprehensive care plan established, implemented, revised, or monitored,
- moderate or high complexity medical decision making;
- first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, 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)

Chronic Care Management

#▲99490 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,
- comprehensive care plan established, implemented, revised, or monitored;
- first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

#+●99439 each additional 20 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)

Chronic Care Management by Physician or Other QHP

#99491 Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, 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.

Time for codes **99487**, **99489**, **99490**, and **99439** is one of the following:

- Time spent solely by clinical staff who have performed CCM activities under supervision of the reporting individual (physician or other qualified health care professional [QHP])

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- A combination of time personally spent by a physician or other QHP and time spent by clinical staff

Medical decision-making (MDM) is a second factor that should be considered in code selection. Codes **99487** and **99489** (complex CCM) are only reported when a patient required moderate- to high-complexity MDM during the calendar month and at least 60 minutes was spent in providing CCM services.

Codes **99490** and **99439** are reported for 20 minutes or more of clinical staff time in a calendar month with no requirement for moderate- to high-complexity MDM.

Time for code **99491** is only the time personally spent by the reporting physician or other QHP. Do not count time spent by clinical staff in the time supporting code **99491**. The level of MDM is not a factor in code selection for **99491**.

All CCM services require establishment, monitoring, or revision (as needed) of a written plan of care for the patient's overall health care needs. Please see your *CPT 2021* reference for full instructions for reporting these services. More information and examples are provided in Chapter 12 of *Coding for Pediatrics 2021*.

The Chronic Care Management Quick Reference table provides a single source for the codes applicable to CCM and complex CCM by type of clinician(s) whose time was spent providing the services, as well as a listing of work, non-facility total, and facility total relative value units (RVUs) for each code or combination of codes reported. Please note that the RVUs for 2021 were not available at time of publication and may differ from the 2020 values included in the quick reference.

Remember, the time and the clinician's signature with credentials (eg, MA, RN, MD) must be included in the documentation of the activities of CCM to support correct code selection.

Chronic Care Management Quick Reference

Performance by and Level of MDM	Report With	2020 RVUs[a]		
		Work	NFT	FT
• Clinical staff[b] • Any level of MDM	20–39 min: **99490** 40–59 min: **99490** and **99439** × 1 ≥60 min: **99490** and **99439** × 2	0.61 1.15 1.69	1.17 2.22 3.27	0.91 1.70 2.49
• Clinical staff[b] • MDM was moderate or high complexity	60–89 min: **99487** 90–119 min: **99487** and **99489** × 1 ≥120 min: Add 1 unit of **99489** for each full 30-min period.	1.00 1.50 +0.50 each added unit	2.56 3.80 +1.24 each added unit	1.48 2.21 +0.73 each added unit
• Physician or QHP only • Any level of MDM	≥30 min: **99491**	1.45	2.33	2.33

Abbreviations: FT, facility total; MDM, medical decision-making; NFT, non-facility total; QHP, qualified health care professional; RVU, relative value unit.

[a]Based on 2020 Medicare Physician Fee Schedule values including values assigned to **G2058** (replaced by **99439** in 2021). Verify actual values in your payer's fee schedule.

[b]May include time spent by a physician or other QHP, when applicable.

Claim Denials: Write Off or Recapture the Revenue?

Approximately 13% of pediatric claims are denied, according to the 2020 Medscape Annual Physician Compensation Report (www.medscape.com/slideshow/2020-compensation-pediatrician-6012743#10; free subscription required). For the typical practice, this means 13% of your earned revenue is at risk if your automated payment entry system or staff write off denied charges without an effort to determine the cause of the denial and potential actions to recoup the denied amount.

If your practice has experienced financial downturns in 2020 (as many have due to the coronavirus disease 2019 pandemic), it might be worthwhile to ask what happens in your practice when claims are denied. How is it decided whether a denied amount is written off, billed to the patient, or submitted as a corrected claim or an appeal to the payer? (Many contracts will not allow billing to patients for services that were denied for reasons such as lack of prior authorization and may require that patients be given advance notification of financial responsibility prior to provision of non-covered services.)

The first step to managing denials is a procedure to promptly recognize and act following receipt of a payer's claim determination. Even with automated payment entry, someone must be responsible for monitoring payer remittances and flagging any unpaid charges for review and potential correction or appeal.

Once identified, denials must be promptly investigated. There may be a time limit for submitting corrected claims or appeals (eg, 180 days from the date of the denial) and this can pass quickly, especially when additional information is needed to correct a denial. Here are some key points for managing investigations into and resolution of denied claims.

Reasons for Denial

When charges are denied, knowledgeable staff should review the denial reasons provided on the payer's remittance advice and determine if the reason given is appropriate based on the services rendered and documented, submitted claim information, and the payer's policies. Many denials can be overturned by submission of either a corrected claim or an effective appeal within the payer's allowed period.

Medical Necessity for Pediatric Services

Learn more about medical necessity and the unique needs of children in the American Academy of Pediatrics policy statement, "Essential Contractual Language for Medical Necessity in Children" (https://pediatrics.aappublications.org/content/132/2/398).

- **Medical necessity denials:** Appeal of a claim denied for lack of medical necessity often requires a joint effort of administrative and clinical staff. Attention should be focused on the payer's policies addressing the service rendered (if any) and any clinical guidelines or published literature that refutes that the service was not medically necessary for management or treatment of the patient's condition or to maintain or recover a patient's abilities.

TIP

Early recognition and action on denials due to lack of medical necessity is important, as the same service may be rendered to the same patient on multiple dates of service. If payment issues are not discovered early and resolved prior to ongoing management or treatment, the risks of lost revenue are increased.

- **Denials due to inaccurate information:** Many claims are denied due to incorrect information submitted on the claim. Common causes are a change in the patient's health plan or policy identification number, incorrect or outdated code utilization, or insufficient information for claims processing (eg, lack of information about the cause of an injury). Often, these denials can be resolved by obtaining correct information and resubmitting the claim. Inaccurate code assignment includes lack of modifiers or incorrect linkage of diagnosis codes to service codes.
- **Denials due to missing information:** A payer's request for information from a patient (eg, accident information) or physician (typically medical records) that goes unanswered may result in a denied claim. These denials are usually avoidable if billing office staff are effectively checking claim status and taking action to ensure payers receive requested information in a timely manner.
- **Denials due to inaccurate claims processing:** Most claims are processed for payment by automated systems that may deny a claim based on out-of-date or inaccurate programming. For a small number of denials due to system processing errors, a payer may instruct the practice to resubmit claims. When a large number of claims are affected, a payer might reprocess all affected claims without requiring the practice to resubmit or appeal each claim. However, even when a payer offers automatic reprocessing of denied charges, practice administrators should verify that all affected claims are reprocessed for payment.

Underpayment

While reviewing remittances for denied claims, identifying underpayments can resolve another avenue for lost revenue. Fee-for-service under contractual agreement is still a major source of income for most physicians. When your practice receives

...continued on page 12

Coding Hotline

CPT®: Subsequent Hospital Care

When I provide a follow-up hospital visit to a patient who has been seen by another physician earlier in the day, can I refer to the history obtained by the other physician rather than repeat that documentation?

This is the case for some elements of history. Under the 1995 and 1997 documentation guidelines for evaluation and management (E/M) services, you can refer to, and update or indicate no changes to, the documented review of systems or past, family, or social history rather than redocument that information. However, you should document the reason for your encounter (ie, chief complaint) and the interval history of present illness (HPI) that you obtain.

When selecting the level of history that includes information documented by another individual, consider only the information that you verified or updated. You should also document the date and location of the information that was reviewed. It is helpful to note items that affect your medical decision-making (eg, "I reviewed Dr Smith's note from earlier today and agree with her documented review of systems including patient's continued headache and nausea, which are inconsistent with the reported injury.").

Subsequent hospital E/M services (**99231–99233**) require an interval history. No past, family, or social history is required for an interval history, although it should be included when a pertinent change has occurred since the last visit (eg, sibling is now ill with same symptoms). The minimum required elements of history for subsequent hospital care are as follows:

99231 Problem-focused interval (chief complaint, 1 element of HPI)

99232 Expanded problem-focused interval (chief complaint, 1 element of HPI, and 1 system reviewed)

99233 Detailed interval (chief complaint, 4 elements of HPI or the status of 3 chronic conditions, review of systems)

TIP

The documentation guidelines for E/M services state, "The medical record *should* clearly reflect the chief complaint." The chief complaint for subsequent inpatient care is often inferred (eg, "The patient continues to have vomiting but hydration is improved.") and, when identifiable without a separate or direct statement, should be acceptable in an audit for level of service or medical necessity. However, a statement of "follow-up" without additional information about the reason for follow-up may raise questions of the level of service and/or clinical indications for the service provided.

Only 2 of the 3 key components (history, examination, and medical decision-making) must support the level of service for subsequent hospital care. The status of the patient at the time of the encounter is also a useful guide in code selection for subsequent hospital care.

99231 Stable, recovering, could be normal

99232 Responding inadequately to therapy or has developed a minor complication

99233 Unstable or has developed a significant complication or a significant new problem, may result in decision to transfer to an intensive care unit

The clinical indications for the second visit on the same date of service should be documented to support the level of service and medical necessity of the visit (eg, planned reevaluation to judge the effectiveness of current management or receipt of test results after the first visit requires a change to the treatment plan).

Have a coding question? Visit **https://form.jotform.com/Subspecialty/aapcodinghotline** to connect with our coding specialists.

Did You Know? **99072**

Code **99072** (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) requires clinical staff time beyond what is typical for an in-person, non-facility service. This includes activities such as prescreening a patient for infectious disease symptoms and instructing the patient on infection precautions that will be used during the visit, as well as time spent donning and removing additional protective gear. Additional supplies and materials used to prevent spread of the infectious disease (eg. personal protective equipment, cleaning supplies) are also included in **99072**.

When a physician or other qualified health care professional (QHP) personally performs these additional tasks that would otherwise be performed by clinical staff (eg, due to unavailability of clinical staff), the **99072** requirement for additional clinical staff time is considered to be met. However, the time spent by the physician or QHP cannot also be attributed to the time of an office visit or other time-based service.

You can earn 0.5 continuing education units from the American Academy of Professional Coders (AAPC) by completing this quiz with a score of 80% or better. Only this newsletter is required to complete the quiz, and you may retake the quiz as often as needed. Simply take the quiz and then visit http://coding.aap.org to enter your answers online and collect your certificate.

0.5 Continuing Education Units

1. What type of history is required to support each level of subsequent hospital evaluation and management (E/M) services?

a. Comprehensive history
b. Problem-focused history
c. An interval history
d. Past, family, and social history

2. What is the typical period in which an appeal of a denied claim will be considered by a payer?

a. 90 days
b. 180 days
c. 1 year
d. 30 days

3. What range of time is included in chronic care management code 99490?

a. 11–31 minutes
b. 30–60 minutes
c. 20–39 minutes
d. 40–59 minutes

4. True or false? For services in 2021, the same level of medical decision-making (MDM) is required to support either 99205 or 99215.

a. True
b. False

5. Which of the following is true of 2021 prolonged service code 99417?

a. **99417** replaces codes **99354** and **99355**.
b. **99417** is reported in conjunction with codes **99201–99205** and **99212–99215**.
c. **99417** is reported only in conjunction with codes **99205** and **99215**.
d. **99417** may be reported when the level of office E/M service is selected based on MDM.

Claim Denials: Write Off or Recapture the Revenue?...continued from page 10

TIP

Practice administrators should create or receive ongoing reports of the number and types of denials received by the practice for use in determining root causes and revised processes to stop or reduce those denials that may have been avoided (eg, lack of prior authorization, patient information not updated) through standardized procedures (eg, obtaining updated insurance information at each encounter).

payments, how do you verify that claims are paid in agreement with your contractual or state-mandated payment policies and fee schedules?

- A billing system may offer a means of loading each payer's payment rate per relative value unit (eg, $40 per unit) or other fee schedule amounts by code for your most commonly provided services and provide an alert when the allowed amount is less than the contracted rate.
- If your billing system does not support verification of fee schedule amounts or contracted rates for individual payers, administrators or managers who are knowledgeable about the practice's fee schedules should routinely review a sample of paid claims to determine whether any services are being paid at a lesser rate. This can happen unintentionally when a practice profile is set up incorrectly or not updated in the payer's automated claims processing system. (This may also prompt recognition that 1 or more physicians in a group practice have been assigned a different fee schedule than their peers. This can happen when new physicians are added to a group but the payer has the physician's profile set to the contractual rate of the physician's former practice.)

Pick Your Battles

Reworking denied claims can be expensive in terms of time and resources. It is important for administrators and billing managers to monitor denials and adopt policies and procedures in the billing office to support efficient denial management. For example, denial of a $10 balance by a secondary payer merits a lower priority for resolution than denial of all claims for a specific service provided in the last 30 days. While this may seem obvious, individual staff working through a list of denied claims may not see the need to prioritize their workload in terms of those denials that are most likely and most profitably overturned.