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Meet the Presenter…

On the topic:
Top Pediatric Coding Updates

Dr. Linda Parsi
2015 Pediatric Coding Updates for the General Pediatrician: What’s Old, What’s New, What’s Coming

Linda D. Parsi MD MBA CPEDC FAAP

Speaker Background

• Medical School at Baylor College of Medicine in 1994
• Pediatric Residency at Baylor College of Medicine from 1994-1997
• Private practice since 1997
• Opened own practice in 2004 to present
• Masters of Business at University of Texas at San Antonio in 2008
• Certified Medical Office Manager in 2010
• Certified Medical Coder in 2012
• President of the San Antonio Pediatric Society 2011 to 2013
• Adjunct Faculty of the UTHSCSA
• Certified Pediatric Coder (CPEDC) in 2014
• AAP Coding Publications Editorial Advisory Board in 2015
Objectives

• Review the Basics of Coding: ICD, CPT, HCPCS
• Pediatric Office Superbill Updates for 2015 by the AAP
• Review ICD-10 Guidelines and Conventions
• Review crosswalks for ICD-9 and ICD-10
• Review coding scenarios
• Review of Billing

Objectives

• And finally the most important objective: is STAYING AWAKE!!!
What’s Old: Basics of Coding

• Critical for providers & staff to be knowledgeable with coding
• Critical to have a team environment when building and maintaining your medical home
• Knowing basic principles can keep your medical home thriving and growing
Coding is Foundation of Medical Home

Coding in a Nutshell

• COMMUNICATING YOUR STORY IN CODES
  – DIAGNOSIS: ICD
  – WORK: CPT
  – SUPPLIES: HCPCS
Basics of Coding: ICD, CPT, HCPCS

- ICD-9, ICD-10 (International Classification of Diseases)
- CPT (Current Procedural Terminology)
- HCPCS Level II (Healthcare Common Procedure Coding System)

ICD-9 CM: Your Diagnosis

- International Classification of Diseases 9th revision, Clinical Modification
- Started in 1979
- Made up of 2 parts: 13,000 codes
  - **Alphabetical Index**: (look up diagnosis or condition)
    - Consists of 2 tables (HTN and Neoplasms)
    - Table of Drugs and Chemicals
    - Index to External Causes (E codes)
Tabular List (more specificity to code diagnosis): End point for code selection which consists of 3, 4 or 5 digits (can be numeric or alphanumeric but only letter is in first position)

- 17 chapters: classifies diseases and injuries (001.0-V91.99)
- 2 supplemental classifications
  - V codes: Factors influencing Health Status and Contact with Health Services (V01-V91) ex: V20.2 well baby check up
  - E Codes: External Causes of Injury and Poisoning (E000-E999)

Contains 4 appendices
- Appendix A: Morphology of Neoplasms (M codes)
- Appendix C: Classification of Drugs
- Appendix D: Classification of Industrial Accidents
- Appendix E: List of Three-Digit Categories

CPT: Your Work

- Current Procedural Terminology: the services and procedures that were done to treat the diagnosis

- Level I Codes: Services and Procedures
  - Evaluation & Management (99201-99499)
  - Anesthesia (00100-01999)
  - Surgery (10021-69990)
  - Radiology (70010-79999)
  - Pathology & Laboratory (80048-89356)
  - Medicine (90281-99199, 99500-99602)
Proper E/M Coding: Your Work

• Levels of E/M services code descriptions:
  • Nature of presenting problem: This drives the Hx, PE and MDM or Time (5 Types)
    – Minimal: may not need physician (ie insect bite)
    – Self-limited/minor: transient in nature (ie URI)
    – Low severity: little risk of morbidity/mortality without tx (ie allergic rhinitis)
    – Moderate severity: moderate risk of morbidity/mortality without tx (ie asthma exacerbation)
    – High severity: risk of morbidity/mortality is high without tx (ie status asthmaticus)
  • History: 3 parts - HPI, ROS, PSFH
  • PE: 19 body areas and organ systems
  • MDM: 3 parts - # of Dx, Data, Risk
  • Time: more than 50% of total time spent in counseling & coordination of care face to face
    – Counseling
    – Coordination of Care

• Need to understand different formats so can pick and choose depending on presenting problem
• Understand 1995 and 1997 Center for Medicare and Medicaid Service (CMS) guidelines so can choose depending on presenting problem for Hx, PE and MDM

Determining Level of E/M: Overall Picture

• Nature of Presenting Problem drives Hx, PE, or MDM

Time: if equal to or greater than 50% was spent in counseling and coordination of care
Proper E/M Coding: History

**HPI – C. S. A. L. T. Q. M. D. (9)**

1. **Context**: happened when playing football
2. **Severity**: pain scale [1-10], improving, worsening
3. **Associated Signs/Symptoms**: blurred vision with headache, cough with runny nose, nausea with vomiting
4. **Location**: (right ear, big toe, head, lower abdomen)
5. **Timing**: persistent, occasionally, twice weekly, daily, 15 minutes after
6. **Quality**: dull, clear, cloudy, thick, throbbing
7. **Modifying Factors**: took ibuprofen without relief, improved with nebulizer treatment
8. **Duration**: 2 days, since last night, 1 week
9. **No. of Chronic Diseases:**

**PMFSH (3)**

- Past Medical History:
  - Current medication
  - Prior illnesses and injuries
  - Operations and hospitalizations
  - Age-appropriate immunizations
  - Allergies
  - Dietary status

**Family History**:

- Health status or cause of death of parents, siblings, and children
- Hereditary or high risk diseases
- Diseases related to CC, HPI, ROS

**ROS (14)**

1. Constitutional symptoms
2. Eyes
3. Ears, nose, mouth, throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Integumentary
9. Musculoskeletal
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/lymphatic
14. Allergic/Immunologic

**Social History**:

- Living arrangements
- Marital status
- Sexual history
- Occupational history
- Use of drugs, alcohol, or tobacco
- Extent of education
- Current employment
- Other

---

### 4 Levels of Hx

<table>
<thead>
<tr>
<th>Problem focused</th>
<th>1995 Guidelines (typically general)</th>
<th>1997 Guidelines (typically specialists)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Proper E/M Coding</strong></td>
<td><strong>Problem focused:</strong></td>
<td><strong>Expanded Problem focused:</strong></td>
</tr>
<tr>
<td><strong>New:</strong> 99201</td>
<td><strong>Established:</strong> 99212</td>
<td><strong>New:</strong> 99202</td>
</tr>
<tr>
<td><strong>CC</strong></td>
<td><strong>Brief HPI:</strong> 1-3 elements</td>
<td><strong>Same as 1995</strong></td>
</tr>
</tbody>
</table>

| **Detailed:** | **New:** 99203 | **Established:** 99214 |
| **CC** | **Extended HPI:** 4 elements or status of 3 chronic conditions | **ROS:** 2 of 6 |

| **Comprehensive:** | **New:** 99204 or 99205 | **Established:** 99215 |
| **CC** | **Extended HPI:** 4 elements | **ROS:** 10 of 14 |
| **Complete PMFSH:** | **Established:** 1 item from 2 areas | **New:** 1 item from all 3 areas | **Same as 1995** |
Example of History:

- **HPI**: used 8 elements
  - **CC**: pt is coughing
  - **Context**: mainly when runs during day and at night
  - **Severity**: keeps up at night
  - **Associated Signs/Sxs**: with fever to 102 for past 2 days
  - **Location**: chest hurts when coughs
  - **Timing**: during the time of fall and winter
  - **Quality**: deep cough with phlegm
  - **Modifying factors**: Tylenol helps fever and used Albuterol twice a day which improves cough
  - **Duration**: for 2 weeks but off and on for 3 months

- **ROS**: used 3 elements
  - Eyes- discharge from eyes, GI- Not eating well but drinking well, GU- good urinary output

- **PFSH**: used 3 out of 3
  - **P**: (PMHX) Personal history of asthma, NKDA, Immun are UTD
  - **F**: (Family Hx related to presenting problem) +mother with asthma as a child and adult
  - **S**: (Social Hx) lives with parents and goes to school

Total for History: HPI-8, ROS-3, PFSH-3 so this is a Detailed History (HPI-4+, ROS-2-7, PFSH-1)

**Level for History** is : New Pt: Detailed 99203
Established Pt: Detailed 99214

---

**Proper E/M Coding:** PE

**Physical Exam: Body Areas/Organ Systems (19)**

<table>
<thead>
<tr>
<th>Body Areas: 7</th>
<th>Organ Systems: 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head</td>
<td>1. Constitutional-2 (3 vitals or gen. appearance)</td>
</tr>
<tr>
<td>2. Neck</td>
<td>2. Eyes-3</td>
</tr>
<tr>
<td>3. Chest (breasts, axilla)-2</td>
<td>3. ENT-6</td>
</tr>
<tr>
<td>4. Abdomen</td>
<td>4. Respiratory-4</td>
</tr>
<tr>
<td>5. Genitalia, groin, buttocks</td>
<td>5. Cardiovascular-7</td>
</tr>
<tr>
<td>7. Each extremity</td>
<td>7. Genitourinary (M-3, F-6)</td>
</tr>
<tr>
<td></td>
<td>8. Heme/Lymphatic/Immunologic—4</td>
</tr>
<tr>
<td></td>
<td>9. Musculoskeletal-6</td>
</tr>
<tr>
<td></td>
<td>10. Integumentary (skin)-2</td>
</tr>
<tr>
<td></td>
<td>11. Neurological-3</td>
</tr>
<tr>
<td></td>
<td>12. Psychiatric-4</td>
</tr>
</tbody>
</table>

Note: 1997 Guidelines may have elements for different body areas/organ systems.
Proper E/M Coding: PE

- Documenting PE: 19 areas for body and organ systems
- Can use either 1995 or 1997 guidelines depending on presenting problem
  - 1995 CMS guidelines: generalists
    - Problem focused = 1
    - Expanded problem focused = 2–7 limited
    - Detailed = 2–7 extended
    - Comprehensive = 8+ systems
  
  OR
  - 1997 CMS guidelines: specialists
    - Problem focused = 1–5
    - Expanded problem focused = 6–11
    - Detailed = 2x6 systems
    - Comprehensive = 2x9 systems

Proper E/M Coding: 4 Levels of PE

<table>
<thead>
<tr>
<th>4 Levels of PE</th>
<th>1995 Guidelines (typically generalists)</th>
<th>1997 Guidelines (typically specialists)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused:</td>
<td>New: 99201 Established: 99212</td>
<td>(1) Limited exam of the affected area or system</td>
</tr>
<tr>
<td></td>
<td>New: 99202 Established: 99213</td>
<td>1-5 elements identified by a bullet in 1 or more systems</td>
</tr>
<tr>
<td>Expanded Problem Focused:</td>
<td>New: 99212 Established: 99213</td>
<td>(2-7 limited) Limited Exam of the affected area or system and other related organ systems</td>
</tr>
<tr>
<td>Detailed Problem Focused:</td>
<td>New: 99203 Established: 99214</td>
<td>(2-7 extended) Extended Exam of the affected area and other related organ systems</td>
</tr>
<tr>
<td>Comprehensive:</td>
<td>New: 99202 or 99205 Established: 99215</td>
<td>(Bx) General multi-system exam requiring 8 or more organ systems or a complete exam of a single organ system</td>
</tr>
<tr>
<td></td>
<td>New: 99204 or 99205 Established: 99215</td>
<td>18 elements: 1. Multisystem exam: at least 9 organ systems or body areas of all elements in each system 2. at least 2 elements in 9 systems 3. Single organ system: all elements identified by a bullet and documentation of every element</td>
</tr>
</tbody>
</table>
Example of PE: using 1995 or 1997 guidelines

PE: used 15 elements from 9 areas
1. Constitutional (2 points): Vitals: Temp-102, Pulse-80, RR-50 (3 out of 7 – 1 point) and ill-appearing (1 point)
2. Head: normal
3. Eyes (2 points): injected conjunctivae, PERRLA
4. ENT (3 points): tympanic membranes-with red TMs with yellow fluid, nose-clear rhinorrhea, oropharnyx-clear
5. Respiratory (2 points): few wheezes, no retractions
6. CV (1 point): no murmurs, RRR
7. GI (2 points): Soft NTND, no HSM
8. GU (1 point): normal
9. Skin (1 point): normal

*1995 Guidelines: Comprehensive: 8+
*1997 Guidelines: Detailed-2x6 (at least 12 elements)

Will use the 1995 guidelines:
New pt: Comprehensive 99204
Established pt: Comprehensive 99215

Proper E/M Coding: MDM

- Medical Decision Making: 3 areas
  - Number of Dx/Tx Options
  - Amount/Complexity of Data
  - Level of Risk
- Use these 3 areas to calculate points and determine level of MDM
- Choose level based on meeting or exceeding 2 out of 3 areas
- 1995 and 1997 guidelines are the same
Proper E/M Coding: MDM
AAP Coding Card 2015

Example of MDM

- **Assessment:** 1. LLL pneumonia  2. Asthma exacerbation  3. Bilateral OM
- **Plan:**
  - Order CXR, spirometry, pulse ox, Asthma control test (ACT test)
  - On same day, discussed results with radiologist and has a small LLL pneumonia
  - Gave prescriptions for Albuterol inhaler with aerocap, Antibiotics for pneumonia, and started inhaled corticosteroids based on review of ACT and spirometry
  - Gave asthma action plan for home and school and explained to mom and patient using pictures on how the medications work and making sure using proper technique for inhalers

**Calculate Level of MDM:**
- # of Dx: **Level High** because over 4 pts
  - LLL pneumonia is a new problem with additional w/u - 4 pts
  - bilateral OM is a new problem with no additional w/u - 3 pts
- **Data:** **Level Moderate** because 3 pts
  - ordered CXR - 1pt
  - ordered spirometry - 1pt
  - discussed with radiologist - 1pt
- **Risk:** **Level Moderate** because presenting problem is moderate and wrote prescription drug management

**Overall MDM:** Based on equalling or exceeding 2 of the 3 elements
- New pt: Level Moderate which is a 99203
- Established pt: Level Moderate which is a 99214
### Proper E/M Coding: MDM (Dx/Mgt)

#### Calculate Dx/Mgt

<table>
<thead>
<tr>
<th>Established Problem</th>
<th>1 point (Max 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established Problem worsening, inadequately controlled, or failing to change as expected</td>
<td>2 points (Max 2)</td>
</tr>
<tr>
<td>New Problem without additional workup</td>
<td>3 points (Max 1)</td>
</tr>
<tr>
<td>New Problem with additional workup</td>
<td>4 points (Max 1)</td>
</tr>
</tbody>
</table>

#### Example: Calculate Dx/Mgt

<table>
<thead>
<tr>
<th>Condition</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma exac</td>
<td>2 points</td>
</tr>
<tr>
<td>Bilateral OM</td>
<td>3 points</td>
</tr>
<tr>
<td>LLL pneumonia</td>
<td>4 points</td>
</tr>
</tbody>
</table>

**TOTAL POINTS:** 9 points

#### Total Level of Dx/Mgt

- **Minimal:** 1 point
- **Low:** 2 points
- **Moderate:** 3 points
- **High:** 4 points

**Total Level of Dx/Mgt:** __High__

### Proper E/M Coding: MDM (Data)

#### Calculating Data Reviewed/Ordered

<table>
<thead>
<tr>
<th>Activity</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order or review laboratory studies</td>
<td>1 point</td>
</tr>
<tr>
<td>Order or review radiology, nuclear medicine studies</td>
<td>1 point</td>
</tr>
<tr>
<td>Order or review other studies (e.g. ECG, EEG, cath, PFTs)</td>
<td>1 point</td>
</tr>
<tr>
<td>Decide to obtain old records OR Decide to obtain hx from someone other than pt</td>
<td>1 point</td>
</tr>
<tr>
<td>Discuss test with performing physician</td>
<td>1 point</td>
</tr>
<tr>
<td>Independently review image, specimen, or tracing</td>
<td>2 points</td>
</tr>
<tr>
<td>Review &amp; summarize old records OR Obtain hx from someone other than pt OR Discuss care w/ other healthcare professional</td>
<td>2 points</td>
</tr>
</tbody>
</table>

**TOTAL POINTS:** 3 points

#### Example: Calculating Data

<table>
<thead>
<tr>
<th>Action</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordered CXR</td>
<td>1 point</td>
</tr>
<tr>
<td>Ordered PFT</td>
<td>1 point</td>
</tr>
<tr>
<td>Discussed w/ Radiologist</td>
<td>1 point</td>
</tr>
</tbody>
</table>

**TOTAL POINTS:** 3 points

**Total Level of Data:** **Moderate**
Proper E/M Coding: MDM (Risk)

### Calculating Risk (based on highest risk noted from table)

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Diagnostic Procedure</th>
<th>Mgt Options</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 self-limited, minor problem</td>
<td>Venipuncture; Chest X-ray; ECG/EEG; Urinalysis; Ultrasound</td>
<td>Rest; Gargle; Elastic bandage; Superficial dressing</td>
<td>Minimal</td>
</tr>
<tr>
<td>2+ self-limited, minor problems OR 1 stable chronic illness OR Acute uncomplicated illness/injury</td>
<td>Physiologic/methemoglobin test; Non-cardiovascular imaging study w/ contrast; Needle biopsy; Arterial puncture; Skin biopsy</td>
<td>OTC drug; Minor surgery, no comorbidities; PT; OT; IV fluids w/out additives</td>
<td>Low</td>
</tr>
<tr>
<td>1 chronic illness w/ mild exacerbation OR 2 stable chronic illness OR Undiagnosed new problem, uncertain prognosis OR Acute illness w/ multiple symptoms OR Acute complicated injury</td>
<td>Physiologic stress test; Diagnostic endoscopy, no comorbidities; Deep needle or incisional biopsy; Cardiovascular imaging study w/out contrast; Obtaining fluid from body cavity</td>
<td>Minor surgery w/ comorbidities; Elective major surgery w/out comorbidities; Rx drug management; Therapeutic nuclear medicine; IV fluids w/ additives; Closed fracture tx</td>
<td>Moderate</td>
</tr>
<tr>
<td>1 chronic illness w/ severe exacerbation OR illness/injury posing threat to life or bodily function OR Acute complicated injury</td>
<td>Electrophysiology study; Diagnostic endoscopy w/ comorbidities; Discography</td>
<td>Elective major surgery w/ documented comorbidities; Emergency major surgery; Parenteral controlled substance; Drug therapy requiring intensive monitoring; Decision for DNR or de-escalation of tx due to poor progress</td>
<td>High</td>
</tr>
</tbody>
</table>

### Example: Calculating Risk

<table>
<thead>
<tr>
<th>Asthma Exac</th>
<th>Chest X-ray</th>
<th>Rx drug management</th>
<th>Total Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODERATE</td>
<td>MINIMAL</td>
<td>MODERATE</td>
<td>MODERATE</td>
</tr>
</tbody>
</table>

### Proper E/M Coding: MDM (2 out of 3)

### Calculating Total MDM

<table>
<thead>
<tr>
<th>Dx/Mgt</th>
<th>Data Reviewed/Ordered</th>
<th>Risk</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 point</td>
<td>1 point – Minimal</td>
<td>Risk Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>2 points</td>
<td>2 points – Low</td>
<td>Risk Low</td>
<td>Low</td>
</tr>
<tr>
<td>3 points</td>
<td>3 points – Moderate</td>
<td>Risk Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>4 points</td>
<td>4 points – High</td>
<td>Risk High</td>
<td>High</td>
</tr>
</tbody>
</table>

### Example: Calculating Total MDM

| 9 points – High | 3 points – Moderate | Moderate | Total MDM: Moderate |
Are you feeling like this yet??

Determining Level of E/M: for New Patient: Need 3 out of 3 for Level (using 1995 guidelines)

<table>
<thead>
<tr>
<th>Problem Focused</th>
<th>Problem Focused</th>
<th># of Dx</th>
<th>Level of E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI 1-3, ROS 0, PFSX 0</td>
<td>1</td>
<td></td>
<td>99201</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>2-7 Limited</td>
<td></td>
<td>99202</td>
</tr>
<tr>
<td>HPI 1-3, ROS 1, PFSX 0</td>
<td>Straight-forward</td>
<td></td>
<td>10 min</td>
</tr>
<tr>
<td>Detailed</td>
<td>2-7 Extended</td>
<td>Low</td>
<td>99203</td>
</tr>
<tr>
<td>HPI 4+, ROS 2-9, PFSX 1</td>
<td>Detailed</td>
<td></td>
<td>30 min</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>8+</td>
<td>Moderate</td>
<td>99204</td>
</tr>
<tr>
<td>HPI 4+, ROS 10+, PFSX 3</td>
<td>Comprehensive</td>
<td></td>
<td>45 min</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>8+</td>
<td>High</td>
<td>99205</td>
</tr>
<tr>
<td>HPI 4+, ROS 10+, PFSX 3</td>
<td>Comprehensive</td>
<td></td>
<td>60 min</td>
</tr>
</tbody>
</table>
### New Patient: Example

**HPI**
- Hx: 19

**ROS**
- Body Areas/Organ Systems: 19

**PMFSH**
- # of Dx Data Risk

<table>
<thead>
<tr>
<th>New Pt</th>
<th>Detailed</th>
<th>Comprehensive</th>
<th>Moderate</th>
<th>Level of E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>99204</td>
<td>99204</td>
<td>99203</td>
<td></td>
</tr>
</tbody>
</table>

**Important:** OR may use **Time** and if equal to or greater than 50% was spent in counseling and coordination of care (i.e., spent 45 min with pt and > than 50% was spent in counseling and coordination of care which is at least 23 minutes face to face then could use the 99204)

### Established Patient – 2 out of 3 for Level (using 1995 guidelines)

**HPI**
- Hx: 19

**ROS**
- Body Areas/Organ Systems: 19

**PMFSH**
- # of Dx Data Risk

<table>
<thead>
<tr>
<th>Nurse Visit</th>
<th>HPI 0, ROS 0, PMFSX 0</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
<th>Level of E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>99211 5 min</td>
<td>99212 10 min</td>
<td>99213 15 min</td>
<td>99214 25 min</td>
<td></td>
</tr>
<tr>
<td>Problem Focused 1</td>
<td></td>
<td>99211 5 min</td>
<td>99212 10 min</td>
<td>99213 15 min</td>
<td>99214 25 min</td>
<td></td>
</tr>
<tr>
<td>Expanded Problem Focused 2-7 Limited</td>
<td></td>
<td>99211 5 min</td>
<td>99212 10 min</td>
<td>99213 15 min</td>
<td>99214 25 min</td>
<td></td>
</tr>
<tr>
<td>Detailed 2-7 Extended</td>
<td></td>
<td>99211 5 min</td>
<td>99212 10 min</td>
<td>99213 15 min</td>
<td>99214 25 min</td>
<td></td>
</tr>
<tr>
<td>Comprehensive 8+</td>
<td></td>
<td>99211 5 min</td>
<td>99212 10 min</td>
<td>99213 15 min</td>
<td>99214 25 min</td>
<td></td>
</tr>
</tbody>
</table>
Calculate Level of E/M
Established Patient: Example

<table>
<thead>
<tr>
<th>Ext Pt</th>
<th>Detailed</th>
<th>Comprehensive</th>
<th>Moderate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hx</td>
<td>HPI 4+, ROS 2-9, PFSX 1 99214</td>
<td>19 Body Areas/Organ Systems 8+ 99215</td>
<td>99214</td>
</tr>
</tbody>
</table>

**Important:** OR may use Time and if equal to or greater than 50% was spent in counseling and coordination of care (ie spent 40 min with pt and > than 50 % was spent in counseling and coordination of care which is 21 minutes face to face than could use the 99215!)

HCPCS: Supplies and Medications

- Healthcare Common Procedure Coding System: medications and/or supplies used during the visit (HCPCS codes)
  - **Level I Codes:** CPT for services and procedures
  - **Level II Codes:** National codes to report other services not in CPT
    - Begin with letters A-V and followed by four numbers
    - Used by physician and non-physician providers (NPs, Speech therapists, ambulance, DME companies (durable medical equipment, prosthetics, orthotics, and supplies – DMEPOS)
    - 5 Types: permanent national codes, dental codes, miscellaneous codes, temporary codes and modifiers

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Modifiers

- Modifiers need to put in proper modifiers for proper claim adjudication to prevent denials and delay of payments
- Need to follow the payer rules

What’s New:
Review of AAP Superbill 2015

Coding: Highlights to Remember

• Coding: Top Points for CPT and HCPCS
  – 96110: remember developmental codes (ie ASQs-Ages and Stages Questionnaires) with the appropriate well exams for 2 months to 66 months
  – 96127: New code for emotional/behavioral assessment (ie Vanderbilt)
  – REMEMBER your medical supplies and medicines with their units!!
  – Understand your administration vaccine codes
  – Practice to understand the guidelines for E/M to correctly code your work
  – Capturing all your work, supplies and medications is critical to keep your practice financially healthy – These codes can mean thousands of dollars per year just by knowing and understanding how to use appropriately

What’s Coming: ICD-10

• Review ICD-10 Guidelines and Conventions
• Review crosswalks for ICD-9 and ICD-10
• Review common coding scenarios
When you think of ICD-10...

Why the Change to ICD-10?  
Top reasons for updating:

• Keeping up with the dramatic changes in medicine, treatments and medical devices.

• ICD-9 not designed to capture all these changes and has been difficult to continue to modify further. There is currently no room for expansion for ICD-9.

• ICD-10 more flexible to adapt to change and better describes the current practice of medicine.
Top reasons for updating:

- Terminology has been modernized and more consistent
- Fewer codes are used because diagnosis and symptoms have been combined to describe a condition
- Provides separate codes for laterality in most conditions
- Able to track more detailed statistics of diseases for public health research, report and surveillance

ICD-10

- International Classification of Diseases 10th revision, Clinical Modification
- To be implemented on October 1, 2015 in the United States
• Made up of 2 parts: 68,000 codes
  – **Alphabetical Index**: (look up general diagnosis or condition)
    • Table of Neoplasms
    • Table of Drugs and Chemicals
    • Index to External Causes
  – **Tabular List**: (more specificity to code diagnosis)
    End point for code selection which consists of 3 to 7 alphanumeric characters
    • 21 chapters: classifies diseases and injuries (A00.0 to T88.9 and Z00 to Z99.8)

---

**ICD-10 Chapters**

1. Infectious and Parasitic Diseases (A00-B99)
2. Neoplasms (C00-D49)
3. Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism (D50-D89)
4. Endocrine, Nutritional, and Metabolic diseases (E00-E89)
5. Mental, Behavioral, and Neurodevelopmental Disorders (F01-F09)
6. Diseases of the Nervous System (G00-G99)
7. Diseases of the Eye and Adnexa (H00-H59)
8. Diseases of the Ear and Mastoid Process (H60-H95)
9. Diseases of the Circulatory System (I00-I99)
10. Diseases of the Respiratory System (J00-J99)
11. Diseases of the Digestive System (K00-K93)
12. Diseases of the Skin and Subcutaneous Tissue (L00-L99)
13. Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)
14. Diseases of the Genitourinary System (N00-N99)
15. Pregnancy, Childbirth, and the Puerperium (O00-O9A)
16. Certain Conditions Originating in the Perinatal Period (P00-P96)
17. Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)
18. Symptoms, Signs and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (R00-R99)
19. Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T98)
20. External Causes of Morbidity (V00-Y99)
21. Factors Influencing Health Status and Contact With Health Services (Z00-Z99)
Review ICD-10
Guidelines and Conventions

• Key Definitions/Symbols:
  – **Character**: a letter or number that make up a code (3 to 7 in ICD-10). All alphabetic characters are used except the letter U.
  – **Code**: a complete set of characters
    - Code Structure: pattern is 3 characters then a decimal point followed by up to 4 characters ie XXX.XXXX
    - First character is an alphabet
    - Second character is a number
    - Remaining characters may be an alphabet or a number and are not case sensitive
    - 4th to 6th characters: expand on the etiology, severity, site, manifestations or intent (i.e. acute, chronic, exacerbated, laterality)
    - 7th characters: is an extension required in some categories to further define the episode of care (i.e. A-initial, D-subsequent, or S-sequelae)
    - Placeholder: uses the letter X to provide for future expansion of a code category or where a seventh character is required but a code is less than 6 characters long so it fills the spaces (ex: poisoning, adverse effect and underdosing codes in Chapter 19)
  – **Category**: a 3-character unit that can serve as the code or base for building a 4 to 7 code from the tabular list

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General Guidelines for Code Selection and Documentation

- ICD-10 begins with the alphabetic index and then the tabular list which is the end point for the code selection because it gives the most specificity
- Choose from A00.0 to T88.9 and Z00 to Z99.8 for diagnosis or reason for encounter
- External causes VO1-Y99 are never coded alone and may be reported in addition to codes from A00.0 to T88.9 and Z00 to Z99.8.
- Signs and symptoms are reported only when a diagnosis has not been established or when not usually associated with the diagnosis

General Guidelines for Code Selection and Documentation

- 4th to 6th Character
  - Etiology: Coding underlying cause or origin of disease or condition
  - Severity: Coding status of condition such as acute, chronic, exacerbated or acute on chronic (ie: if a condition is both acute and chronic and are listed at the same indentation level in the alphabetic index then both can be reported at the same time)
  - Site: ICD-10 has separate codes for laterality in most conditions where laterality apply. Some codes may have right, left and/or bilateral. If it does not have a listing for bilateral then code right and left together
  - Manifestations: Characteristic signs or symptoms of an illness
  - Intent
General Guidelines for Code Selection and Documentation

• Seventh character
  – A: for initial encounter or Active treatment such as surgical treatment, emergency department and evaluation, and continuing treatment by the same or a different physician (ex: initial burn)
  – D: for subsequent encounter or follow-up care after the initial encounter that the pt was treated (ex: follow-up burn)
  – S: Sequelae (late effects) are reported when there is a complication or condition that occurs after an injury. The sequelae is coded first (ex: scar) and the initial problem is coded second (ex: sequela of a burn)

• Combination Code uses a single code that can describe a single condition with secondary associations or multiple conditions
• Documenting and coding conditions such as congenital, acquired, neonatal
ICD-10 Coding Scenarios

• Sick Visit
  – 7 y/o WM presents with a CC of sore throat, rash and fever
  • Dx: 1. J02.0 Strep pharyngitis
    2. A38.9 Scarlet fever, uncomplicated
    Note: fever not included because assumed in J02.0

Crosswalks from ICD-9 to ICD-10

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>034</td>
<td>J02</td>
</tr>
<tr>
<td>4th</td>
<td>Acute Pharyngitis</td>
</tr>
<tr>
<td>034.0</td>
<td>J02.0</td>
</tr>
<tr>
<td>Strep Pharyngitis</td>
<td>Strep Pharyngitis/Sore Throat</td>
</tr>
<tr>
<td>034.1</td>
<td>A38</td>
</tr>
<tr>
<td>Scarlet Fever</td>
<td>Scarlet Fever</td>
</tr>
<tr>
<td>Excludes parascarlatina (057.8)</td>
<td>Includes: scarlatina</td>
</tr>
<tr>
<td></td>
<td>Excludes2: strep sore throat (J02.0)</td>
</tr>
<tr>
<td></td>
<td>Excludes2: chronic pharyngitis (J31.2)</td>
</tr>
<tr>
<td></td>
<td>Excludes2: strep pharyngitis/Sore Throat</td>
</tr>
<tr>
<td></td>
<td>Excludes2: Scarlet fever (A38.-)</td>
</tr>
</tbody>
</table>

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ICD-10 Coding Scenarios

• Well Visit
  – A 10 day old BF presents for a wellness exam without any problems
    • Dx: 1. Z00.110

Crosswalks from ICD-9 to ICD-10

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>V20.31 Health Supervision for Newborn</td>
<td>200.11 Health Check for Child Under 29 days old</td>
</tr>
<tr>
<td>Under 8 days old</td>
<td>Use additional code to identify any abnormal findings</td>
</tr>
<tr>
<td>Excludes: health check for child over</td>
<td>Excludes1: health check for child over 28 days old</td>
</tr>
<tr>
<td>28 days (V20.2)</td>
<td>(200.121, 200.129)</td>
</tr>
<tr>
<td>V20.32 Health Supervision for Newborn</td>
<td></td>
</tr>
<tr>
<td>8 to 28 days old</td>
<td>200.110 Health exam for newborn; under 8 days old</td>
</tr>
<tr>
<td>Excludes: health check for child over</td>
<td></td>
</tr>
<tr>
<td>28 days (V20.2)</td>
<td>200.111 Health exam for newborn 8 to 28 days old; Newborn weight check</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>V20.2 Routine Infant or Child Health Check</td>
<td></td>
</tr>
<tr>
<td>over 28 days old</td>
<td></td>
</tr>
<tr>
<td>Excludes: health check for child under</td>
<td></td>
</tr>
<tr>
<td>29 days old (V20.31-V20.32) special</td>
<td></td>
</tr>
<tr>
<td>screening for developmental handicaps (V79.3)</td>
<td></td>
</tr>
</tbody>
</table>

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ICD-10 Coding Scenarios

• Sick & Well Visit
  – 2 y/o HM presents for a well exam and follow-up evaluation of a burn on chest 3 months ago when patient reached for coffee mug on counter containing hot water, had initial and subsequent care done in Mexico
• Dx: 1. Z01.121 Encounter for routine child health exam with abnormal findings
  2. L90.5 Scar conditions and fibrosis of skin
  3. T21.22XS Burn of second degree of chest wall sequela
  4. X12.XXXS Contact with other hot fluids sequela
Review of Billing
Highlights to Remember

• For ICD-10 there will be up to 12 diagnosis spaces that can be reported instead of 4 diagnosis on the CMS 1500 for billing
• Remember to link ICD to CPT
• Remember to discuss with EHR, clearinghouses to make sure all ready and keep close tabs during transition for denials
• Concern for payment delays during transition (look at AR for pt and insurance and work on balances to keep cash flow up now)
Congratulations You Made it!!

• Remember we are all a team to help each other help our children!!
• To do this we need to stay current on coding updates so that our medical homes can stay financially healthy and keeping the joy of medicine!
AAP Pediatric Coding References

Brand New!!
This is a Pediatric ICD-10-CM manual. It is set up just like the big ICD-10 manual, however it differs because:
• Adult only conditions are removed
• Facility-based guidelines are not included and been removed (we don’t use them)
• Thus making it a more manageable sized book
• Code and Chapter level guidelines can be found with the code and chapter they correspond to!
• No more searching around for guidelines that may or may not exist!

AAP Pediatric Coding References

- Published annually
- The signature publication in a comprehensive suite of coding products offered by the AAP.
- This AAP exclusive complements standard coding manuals with pediatric-specific documentation and billing solutions for pediatricians, nurse practitioners, administration staff, and pediatric coders.
This manual takes the most commonly reported ICD-9-CM codes and “crosswalks” them to their respective ICD-10-CM code. This manual

• is a nice complement to the Pediatric ICD-10-CM manual and should not be used alone after implementation. (Recommend getting both to assist with the transition)

• will help you become familiar with the new code set and where to find the codes in the big manual when you go to actually use them

• will show you where there is more detail needed to get to a specific code (will help prepare you now to work with physicians on their documentation if it does not contain that detail)

• Comprehensive manual for pediatric ICD-10-CM coding that details the many overarching guidelines and chapter specific guidelines

• Used as a resource in conjunction with the manual to help navigate the many new guidelines, specifically the new code structure; new parentheticals; new layout

Some features include

• key terms highlighted for help with improved understanding

• highlighted text boxes to call attention to important difference between the ICD-9-CM and ICD-10-CM code structure

• applications, practical opportunities to apply knowledge learned
AAP Pediatric Coding References

Monthly newsletter with hard copy and online access
- Contains a “Transition to Ten” column - became a recurring column in January 2011
- Subscription to the newsletter allows online access to all back editions of the column, which contains helpful tips and clinical scenario coding
- Stay up-to-date on pediatric coding to increase your compliance and revenue!

For All Pediatric Coding Needs

- AAP Publications
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- AAP Coding resources
- [www.aap.org/coding](http://www.aap.org/coding)
Questions???

Thank you very much for the privilege to speak to you today and I hope this information will be helpful.

Any questions you can email at

linda@drparsi.com

The End

References

- Pediatric Code Crosswalk: ICD-9-CM to ICD-10-CM
- Principles of Pediatric ICD-10-CM Coding
- Coding for Pediatrics, 2014
- Quick Reference Card for Pediatric Coding & Documentation, 9th Edition
- AAP Pediatric Coding Newsletters
- CMS.gov website