Overcoming Challenges in Pediatric Coding and Reimbursement

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1

Evaluation and Management

Examples

Bonus Material:

- Well-child Care
- Common Office Procedures
- Diagnosis Issues in Pediatrics

2

Office Visits

Visits are coded based on either Time or Medical Decision-Making

Medically appropriate History and Examination must still be documented

3

Time - What Counts?

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

4

Time – What Does Not Count?

- clinical staff time
- time spent performing separately reported services
- travel time
- teaching that is general and not limited to discussion that is required for the management of a specific patient

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Coding by Time

	Time		Time
		99211	Not specified
99202	15	99212	10
99203	30	99213	20
99204	45	99214	30
99205	60	99215	40

- Clinical staff time DOES NOT count!
- Only one person per minute – if two providers see patient at same time, only one would be counted for each minute.

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Prolonged Services

99417 - Prolonged office or other outpatient evaluation and management service(s) (beyond the total 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 (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

*Not all payers reimbursing for prolonged services.

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Medical Decision-Making

E/M Office Level of Medical Decision Making (MDM) and TIME **Effective January 1, 2021**

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	**Straightforward** 15-29 min 10-19 min	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213	**Low** 30-44 min 20-29 min	**Low** • **2** or more self-limited or minor problems; or • **1** stable chronic illness; or • **1** acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* or **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**
99204 99214	**Moderate** 45-59 min 30-39 min	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • **2** or more stable chronic illnesses; or • **1** undiagnosed new problem with uncertain prognosis; or • **1** acute illness with systemic symptoms; or • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
99205 99215	**High** 60-74 min 40-54 min	**High** • **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

PROLONGED SERVICES *Used only when billing based upon time. Used only with level 5.*
+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 of total time.
+G2212- Prolonged office or other outpatient evaluation and management service(s) beyond the **maximum** required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (Medicare)

Adopted from AMA Table Levels of MDM

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Number and Complexity of Problems *Addressed*

Code	Level of MDM [illegible]	Number and Complexity of Problems Addressed
[illegible]	N/A	N/A
[illegible]	Straightforward	Minimal [illegible]
[illegible]	Low	Low [illegible]
[illegible]	Moderate	Moderate [illegible]
[illegible]	High	High [illegible]

- To receive credit in this category, the problem must be addressed:
  - Management
  - Diagnostic studies ordered
  - Consideration of further treatment even if declined by patient
- Listing a diagnosis without documentation of "management" does not count – prescription, ordering of diagnostic tests, counseling
- Notation that condition is managed by another provider or referral without further workup or consideration of treatment does not qualify
- A problem that is not at treatment goal is not "stable"
- A systemic symptom in an otherwise minor illness will be coded to acute, uncomplicated (Low) rather than acute illness with systemic symptoms (Moderate)

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Key Definitions from the AMA

- Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be single system. Moderate - 99214
- Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. Moderate - 99214

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Examples from the American Academy of Pediatrics

Low

- fever in the context of classic URI symptoms
- newborn infant who we expect to lose 5-10% of body weight
- teenager in the context of exertion yesterday OR chest pain which worsens when sternum is pressed in teen girl after cough illness
- kid falling asleep during 8 AM class, admitting to staying up later.

Moderate

- fever in the context of recent tick bite
- kid with joint pain, or kid with polydipsia/polyuria, or kid with tachycardia/goiter
- teen girl also with butterfly rash on face OR school aged boy also with non-blanching rash on legs and butt, and belly pain and Coke colored urine
- falling asleep multiple times per day without warning, also with falling to the floor suddenly and hallucinations and sleep paralysis

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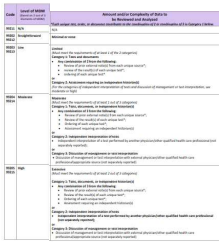
Amount and/or Complexity of Data to be Reviewed and Analyzed



- Separate credit given for multiple tests or review of prior external notes from multiple sources
- Tests that do not have a professional component (such as labs) are counted as Data even if practice is billing for the test
- Credit for independent historian is given when the patient is unable to give their own history
- Discussion of a test not ordered is still counted as Data

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Risk of Complications and/or Morbidity or Mortality of Patient Management

- Lack of examples is intentional: "clinician judgment within patient context"
- Prescription Drug Management
  - does not require a change in dosage, addition of a new med
  - any prescription discussed in management of the patient qualifies
- Intensive monitoring for High complexity
  - not less than quarterly if long-term
  - may be short-term
  - by a lab test, a physiologic test or imaging - monitoring by history or examination does not qualify
  - affects the level of medical decision making in an encounter in which it is considered in the management of the patient.

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- Potential health hazards related to socioeconomic and psychosocial circumstances
- May be coded from other than treating physician documentation
- Never coded primary

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Examples of SDOH Codes

- Z55.3 – Underachievement in school
- Z55.4 – Educational maladjustment and discord with teachers and classmates
- Z59.00 – Homelessness
- Z59.41 – Food insecurity
- Z59.7 – Insufficient social insurance and welfare support
- Z60.3 – Acculturation difficulty
- Z62.0 – Inadequate parental supervision and control
- Z62.1 – Parental overprotection
- Z62.21 – Child in welfare custody
- Z62.23 – Child in custody of non-parental relative
- Z63.31 – Absence of family member due to military deployment
- Z63.72 – Alcoholism and drug addiction in family

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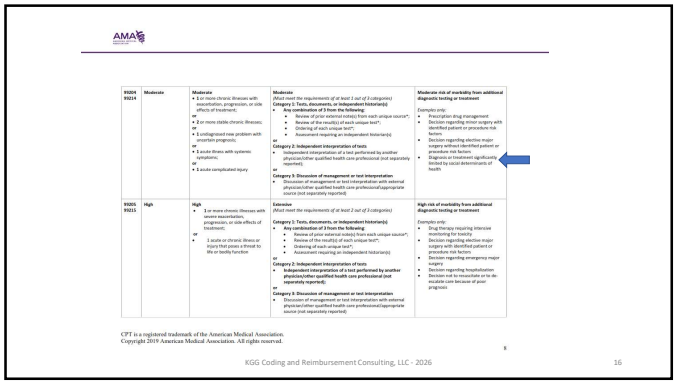

99204
99214
	Moderate	**Moderate**
		• 3 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ Review of the result(s) of each unique test*;
			  ▪ Ordering of each unique test*;
			  ▪ Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ Review of the result(s) of each unique test*;
			  ▪ Ordering of each unique test*;
			  ▪ Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

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Making the Leap to 99205/99215

- Time of 60 minutes for 99205 or 40 minutes for 99215
- High Complexity Medical Decision-Making – 2 out of 3
  - Chronic illness(es) with severe exacerbation, progression, or side effects of treatment OR acute or chronic illness or injury that poses a threat to life or bodily function
  - Two out of Three:
    - At least 3 unique tests reviewed or a combination of tests reviewed, review of external notes, ordering of unique test, assessment of independent historian
    - Independent interpretation not separately billed
    - Discussion of management or test interpretation
  - High risk of morbidity from additional diagnostic testing or treatment

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+G2211

Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

- Not to be used if only see patient for routine or acute problems
- Medicare guidance: Cannot be billed at an encounter in which modifier 25 is applied to the E/M due to procedure

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Example #1

12yo is seen in the office for ADHD and anxiety follow up. Child is on Adderall and sertraline. They are working with a psychologist every other week. 15 minutes spent in the visit. No changes to current medications.

Medical Decision Making

- Number and Complexity - Moderate: Two stable chronic illnesses - 99214
- Data - Straightforward: No data reviewed - 99212
- Risk - Moderate: Prescription drug management – 99214

(Recommend more detail in how patient is responding to meds and any other significant issues.)

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Example #2

2yo seen in the office for fever and a rash. Also with cough and runny nose for 3 days. Not sleeping well. No previous ear infections. On exam found to have an ear infection and oral antibiotics prescribed. The rash is a contact dermatitis and recommended treatment with OTC hydrocortisone. 15 minutes spent in the visit.

Medical Decision-Making

- Number and Complexity - Low/Moderate: Acute, uncomplicated illness – 99213
- Data - Straightforward: No data reviewed - 99212
- Risk - Moderate: Prescription drug management – 99214

Time of 15 minutes supports 99212 – but MDM is higher

(Was there anything that would have elevated the complexity of the problem, that would support the criteria: "systemic symptoms and has a high risk of morbidity without treatment" ?)

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Example #3

17yo is seen in the office for evaluation of an eating disorder. She is avoiding and restricting her eating. Her vitals are normal, but her weight is down 15 pounds since last checked. She is seeing a psychologist weekly. Her exam otherwise is within normal limits. Labs are sent out and will not be available until the next day. 35 minutes spent in the visit. She is scheduled to come back for her next check in 2 weeks.

Medical Decision-Making

- Number and Complexity - Moderate: Chronic illness with exacerbation - 99214
- Data - Low/Moderate?: How many unique tests ordered? – 2 = 99213; 3+ = 99214
- Risk - Moderate: ????

Time of 35 minutes supports 99214

(Weight is down since last checked, but when was that? What labs are being monitored?)

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Example #4

5yo seen in the office for a sore throat and fever. Rapid test for COVID is negative and rapid test for strep is positive. Antibiotics prescribed. Physician in the room 15 minutes, broken up before and after the lab testing. Patient in room for 25 minutes.

Medical Decision-Making

- Number and Complexity - Low: Acute uncomplicated illness - 99213
- Data - Low: 2 tests ordered, reviewed - 99213
- Risk - Moderate: Prescription drug management – 99214

Total time spent by provider not documented.

(If total time by provider on DOS is 30 minutes or more, 99214 would be supported.)

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Example #5

7yo patient previously diagnosed with asthma presents with acute exacerbation. Physician recommends hospitalization, but parent declines, wanting to wait "to give breathing treatments a chance"

Medical Decision-Making

- Number and Complexity - Moderate/High?: Chronic illness with mild exacerbation – 99214 or chronic illness with severe exacerbation – 99215
- Data – straightforward – no data
- Risk – High: Decision regarding hospitalization – 99215

(Document discussion with parent re recommendation for hospitalization.)

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Example #6

Medically appropriate history and exam performed and documented.

Plan

- Discussed giving enough miralax so that he has 1-2 soft poops daily. Discussed miralax clean-out every weekend for a month, then once a month after that. Recommended giving him time every day after breakfast and before bed to sit on the toilet. Increase miralax dosage until he is having 1-2 soft poops a day.
- Following cleanout - begin daily Miralax. Take as directed for constipation. Dissolve in 6-8oz clear liquid. Titrate for soft stool. Goal is 1-2 soft stools every day to every other day without pain, straining, or hard stools. Stool should be the consistency of soft-serve ice cream
- Increase water intake
- Recommend high fiber diet
- Structured toilet sitting recommended 3-4 times daily after meals & before bedtime
- Return to clinic with persistent or worsening symptoms despite current measures

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Example #6 - Coding

Billed as 99214

Number and Complexity – Moderate – chronic illness with exacerbation - 99214

Data – Straightforward: no data - 99212

Risk – Low – 99213

MDM supports 99213

If the provider spent 30 minutes or more AND documented time, would support 99214

(Miralax would be considered low complexity unless the patient had other issues that created risk. Perhaps document other considerations if Miralax does not work.)

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Example #7

CC/HPI: contraceptive consult Pt presents to clinic today to discuss contraception. She reports she does not want the shot. She states she is interested in taking a daily pill. Denies any menstrual concerns.

Medically appropriate history and examination documented.

Assessment:

- OCP consult. Medications reviewed and discussed with patient/parent. *(Was the parent present?)*
  - DX 1: Z30.8 Encounter for other contraceptive management
  - DX 2: Z30.09 Encounter for oth general cnsl and advice on contraception *(Should not code both – there is a more specific code – Z30.011 - Encounter for initial prescription of contraceptive pills)*

Plan:

- OCP CONSULT/CONTRACEPTIVE COUNSELING - Educated on different contraceptives. Discussed the risks involved with having multiple sex partners and not using protection. Reminded that while options help prevent pregnancy, OCP does not protect against STD's. Reminded patient that it is ultimately her decision to start contraception. Confidentiality agreement discussed. Will begin trial of OCP. R/B/A discussed. *(Were there any risks or benefits specific to this patient?)* Recheck in office as needed.

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Example #7 - Coding

Billed as 99214 – but documentation does not support billing as problem-oriented visit.

What "problem" is being addressed?

CPT guidance is that when contraceptive counseling is the only purpose of the visit, the correct code is preventive medicine counseling. Time must be documented to support the preventive medicine counseling codes. Payers may have more specific guidance.

99401 – 15 minutes

99402 – 30 minutes

99403 – 45 minutes

99404 – 60 minutes

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Example #8

Documentation supports 99214. This statement is included at the end:

"Today's history and physical exam were performed by K D CRNP under the supervision and direction of L W CRNP. I attest that the above documentation was discussed with and agreed upon by L W CRNP."

Services were billed under L W CRNP.

There is no provision for supervising and billing services for CRNPs as there would be for residents. The service should be billed under the provider who has performed and documented the medically appropriate history and examination and taken responsibility for the medical decision making.

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Example #9

Medically appropriate history and exam were performed and documented.
Assessment
- Cerumen Impaction
- Adjustment disorder w/ anxiety
- Pain in left hip, chronic illness/stable but persistent

I attest that 55 minutes were spent on direct patient care on today's DOS.
Counseling
Plan
CERUMEN IMPACTION
- Discussed impaction of ear wax. Ear irrigation performed.
- At home care discussed.

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Cerumen Removal

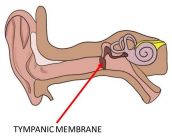
- 69210 – unilateral

  Not just lavage – must require the skill of the physician to remove

  Some insurers specify that certain tools be used – e.g., "scoop"
- 69209 - Removal impacted cerumen using irrigation/lavage, unilateral

  performed by clinical staff

Cannot bill both at same session/same ear



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Example #9 - Coding

Billed as 99215-25, 69209

I attest that 55 minutes were spent on direct patient care on today's DOS.

(Should specify that time was exclusive of separately billable procedures.)

Counseling

Plan

CERUMEN IMPACTION

- Discussed impaction of ear wax. Ear irrigation performed.

(Who performed irrigation? Were both ears irrigated? If so, add modifier 50.)

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Telehealth

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Documentation for Telehealth Services

- Informed consent
  - May be verbal or signed through the patient portal or mail.
  - https://telehealth.hhs.gov/providers/preparing-patients-for-telehealth/obtaining-informed-consent
- Location of the provider and the patient
  - Provider must be licensed in the state where the patient is located
- Technology used – must be HIPAA-compliant
  - Must have Business Associate Agreement with telehealth technology provider
  - Must specify whether audio-video or audio-only
- Documentation to support the code billed
- Other information as required by the specific payer

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Audio-Video – New Patient

- 98000 - Synchronous audio-video visit for evaluation and management of new patient, including medically appropriate history and straightforward medical decision making. If using time, at least 15 minutes of total time on the encounter date must be met.
- 98001 – low medical decision making – 30 minutes
- 98002 – moderate medical decision making – 45 minutes
- 98003 – high medical decision making – 60 minutes

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Audio-Video – Established Patient

- 98004 - Synchronous audio-video visit for evaluation and management of established patient, including medically appropriate history and straightforward medical decision making If using time, at least 10 minutes of total time on the encounter date must be met.
- 98005 – low medical decision making – 20 minutes
- 98006 – moderate medical decision making – 30 minutes
- 98007 – high medical decision making – 40 minutes

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Audio-Only – New Patient

- 98008 - New patient synchronous audio-only visit with straightforward medical decision making and more than 10 minutes of medical discussion, if using time 15 minutes or more
- 98009 – low medical decision making – 30 minutes
- 98010 – moderate medical decision making – 45 minutes
- 98011 – high medical decision making – 60 minutes

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Audio-Only – Established Patient

- 98012 - Established patient synchronous audio-only visit with straightforward medical decision making and more than 10 minutes of medical discussion, if using time 10 minutes or more
- 98013 – low medical decision making – 20 minutes
- 98014 – moderate medical decision making – 30 minutes
- 98015 – high medical decision making – 40 minutes

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Audio-Only Codes Not the Same as Telephone Call Codes!

- No restriction as to E/M 7 days prior or next 24 hours
- Not restricted to established patients
- Not required to be patient initiated
- Coded by time or MDM
- Prolonged services codes may be used

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Telemedicine Services

Service	New or Established	Synchronous	Coded By	Time Frame	Other
Synchronous A/V 98000 - 98007	Both	Yes	MDM or total time on date of service	Single calendar day	Can't bill with same day E/M
Synchronous Audio Only 98008 - 98015	Both	Yes	MDM or total time >10 minutes medical discussion	Single calendar day	Can't bill with same day E/M
Brief Communication Technology Based Service 98016	Established	Yes	A single 5-10 minute medical discussion	Single calendar day	Not related to E/M 7 days prior or leading to E/M in next 24 hours

Adapted from CPT® 2026 Professional

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Telehealth Concerns

- Not all payers cover telehealth
- Coverage may be plan-specific
- Some plans only cover telehealth for established patients
- In some cases, payers may have other coding requirements
  - Example, BCBS accepts audio-only codes but requires audio-video visits to be billed with office visit codes

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Preventive Medicine

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Preventive Medicine

- Visits
  - New vs. Established Patient
  - Based on patient's age
  - Guidelines established by specialty societies
- Counseling
  - New or Established Patient
  - Time-Based

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Preventive Medicine Codes

99381/99391 – under 1 year
99382/99392 – 1- 4 years
99383/99393 – 5 – 11 years
99384/99394 – 12 - 17 years

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CPT Guidance

"If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine service, and if the problem is significant enough to require additional work to perform the key components of a problem-oriented E&M service, the appropriate Office/Outpatient code should also be reported…Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable E&M service was provided…."

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Preventive Medicine Counseling

- For patients who do not have symptoms or established illnesses for which the counseling is provided
- Time-based
- May be provided/billed at same visit as E&M
- Some payors may ignore CPT guidelines and ask that you bill this with visit code in order to provide a separately covered service

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Preventive Medicine Counseling

Individual
- 99401 – 15 minutes
- 99402 – 30 minutes
- 99403 – 45 minutes
- 99404 – 60 minutes

Group
- 99411 – 30 minutes
- 99412 – 60 minutes

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Diagnosis Coding for Well Child Care

- Z00.110 – Health examination for newborn under 8 days old
- Z00.111 – Health examination for newborn 8 to 28 days old
- Z00.121 – Encounter for routine child health examination with abnormal findings
  Use additional code to identify abnormal findings
- Z00.129 – Encounter for routine child health examination without abnormal findings
- Z00.2 – Encounter for examination for period of rapid growth in childhood
- Z00.3 – Encounter for examination for adolescent development state
- Z76.81 – Expectant parent(s) prebirth pediatrician visit

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Abnormal Findings

"An examination with abnormal findings refers to a condition/diagnosis that is newly identified or a change in severity of a chronic condition (such as uncontrolled hypertension, or an acute exacerbation of chronic obstructive pulmonary disease) during a routine physical examination."

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Vaccine Administration

Codes for administration with counseling – for patients age 18 and under

- 90460 – first vaccine/toxoid component
- 90461 – each additional vaccine/toxoid component

Counseling must be performed by physician and must be documented for each component

All routes of administration

Use 90460 for each vaccine administered

Use 90471, 90472 for each injection if no counseling

For medicolegal reasons, documentation should include dose, lot#, site, name and credentials of person administering.

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Example

2-month old infant receives the following immunizations according to schedule

DTaP – 90460, 90461, 90461, 90700

Rotavirus – 90460, 90681

Hepatitis B and HiB – 90460, 90461, 90748

Poliovirus – 90460, 90713

Pneumococcal vaccine – 90460, 90670

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Respiratory Syncytial Virus (RSV) Immunization

Remember to use 96380, 96381 for administration of RSV immunization.

- 96380 - Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional
- 96381 - Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection

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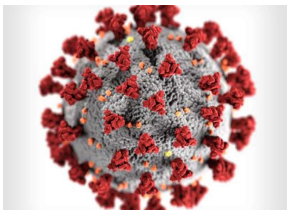
COVID Vaccine Administration

New code in 2026 for each additional component

- +90481 - Immunization administration by intramuscular injection, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine; each additional component administered



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Immunization Counseling

- 90482 - Immunization counseling by physician or other qualified health care professional when immunization(s) is not administered by provider on the same date of service; 3 minutes up to 10 minutes
- 90483 - greater than 10 minutes up to 20 minutes
- 90484 - greater than 20 minutes

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Reviewed Vaccines

Vaccine Type	Date	Age	Amt	Route	Site	NDC	Lot #	Mfr.	Exp. Date	Date on VIS	VIS Given	Vaccinator
Diphtheria, Tetanus, Pertussis												
DTaP	03/19/19	1y6mo	0.5 mL	Intramuscular	Thigh, Right		hy0g7	GlaxoSmithKline	09/13/19	08/24/18	03/19/19	Shay Bowen
DTaP-IPV	03/12/18	5m0d	0.5 mL	Intramuscular	Thigh, Right		af043	GlaxoSmithKline	11/15/18	05/17/07	03/05/18	Rhonda Ramsey
DTaP-Hib-IPV	01/05/16	4m0d	0.5 mL	Intramuscular	Thigh, Right		C0345AA	Sanofi Pasteur	05/27/16	05/17/07	01/05/16	Iris Bradford
DTaP-Hep B-IPV	11/10/17	3m4d	0.5 mL	Intramuscular	Deltoid, Right		92443	GlaxoSmithKline	08/11/19		11/10/17	Shay Brown
Haemophilus Influenzae Type B												
Hib-(PRP-T)	09/21/18	1y0mo	0.5 mL	Intramuscular	Vastus Lateralis, Right		e004ee	Sanofi Pasteur	11/17/19	04/02/15	09/21/18	Patty Griffith
Hib-(PRP-T)	03/12/18	6m0d	0.5 mL	Intramuscular	Thigh, Left		U7594AA	Sanofi Pasteur	06/01/18	04/02/15	03/05/18	Rhonda Ramsey
DTaP-Hib-IPV	01/05/16	4m0d	0.5 mL	Intramuscular	Thigh, Right		C0345AA	Sanofi Pasteur	05/27/16	04/02/15	01/05/16	Iris Bradford
Hib-(PRP-T)	11/10/17	3m4d	0.5 mL	Intramuscular	Deltoid, Left		U7597AA	Sanofi Pasteur	07/06/19		11/10/17	Shay Brown
Hepatitis A												

Assessment / Plan

1. **Well child** - Daniel is a 18 month old Well-appearing boy presenting for WCC. Growing and developing well. Weight/ BMI / and head circumference within normal average. No concerns about vision or hearing.

-PE WNL
-Anticipatory guidance discussed, including signs of illness.
-Mom advised to try lactaid milk since he has not tolerated other milks. He may have lactose intolerance.
- Immunization as below.
- RTC for 2 year check.
  Z00.129: Encounter for routine child health examination without abnormal findings
  - CHILD'S WELL VISIT, 18 MONTHS: CARE INSTRUCTIONS
  - INFANRIX (DTAP)(PF) 25 LF UNIT-58MCG-10 LF/0.5ML INTRAMUSCULAR SYRINGE - DTaP Site: Thigh, Right
    Qty: 0.5 mL Administered 03/19/2019 Perform Date: 03/19/2019

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Separate OV with Preventive Medicine?

HPI

Danniel is an 18 mo. male presenting for WCC.

He has been doing well. Plays with his siblings. He has been eating well. Mom continues to feed formula. She reports he does not tolerate regular milk or blue top milk, he gets diarrhea and colic.

Mom does not have any concerns at this time.

ROS

Parent reports **has not started whole milk** but reports drinks from cup (no bottle), table foods, 3 meals/day, and well balanced diet. (S)he reports brushes childs teeth with soft toothbrush and fluoride in water. (S)he reports sleeps through the night. (S)he reports normal wet diapers, normal bowel movement frequency, and normal consistency. (S)he reports turns pages of book. (S)he reports runs, walks backwards, and climbs on furniture. (S)he reports knows 7+ words. (S)he reports feeds self with utensils. (S)he reports no smokers in home and car seat facing backwards. (S)he reports plans daycare--home based. (S)he reports reads to child and minimal TV viewing.
ROS as noted in the HPI

Physical Exam

Patient is an 18-month-old male.

General Appearance: General: awake, smiling, and alert and active. Te

Head: Appearance: no skull molding.

Eyes: External Eye: no discharge. Conjunctiva: non-injected and non-ics

Ears, Nose, Throat: Ears: **There was blood remnants present on right by ENT).** Nose: patent. Oral Cavity: teeth present.

Assessment / Plan

1. Well child - Daniel is a 18 month old Well-appearing boy presenting for WCC. Growing and developing well. Weight/ BMI / and head circumference within normal average. No concerns about vision or hearing.
-PE WNL
-Anticipatory guidance discussed, including signs of illness.
-Mom advised to try lactaid milk since he has not tolerated other milks. He may have lactose intolerance.
- Immunization as below.
- RTC for 2 year check.
  Z00.129: Encounter for routine child health examination without abnormal findings
  - CHILD'S WELL VISIT, 18 MONTHS: CARE INSTRUCTIONS
  - INFANRIX (DTAP)/PF) 25 LF UNIT-58MCG-10 LF/0.5ML INTRAMUSCULAR SYRINGE - DTaP Site: Thigh, Right
    Qty: 0.5 mL Administered 03/19/2019 Perform Date: 03/19/2019

2. Hematotympanum - On right ear.
- Patient being followed by ENT about this.
  H73.899: Other specified disorders of tympanic membrane, unspecified ear

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Common Office Procedures

- Laceration Repairs
- Closed Treatment of Fractures
- Removal of Foreign Body
- Nebulizer Treatments

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Laceration Repairs

Coded by length, site, and type of repair – common sites are added together – use one code

Use of tissue adhesives (Dermabond) – coded as simple repair – cannot code separately for supply of adhesive.

Closure with steri-strips coded as E&M

Local anesthesia included in repair code

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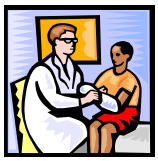
Global Fracture Care

Restorative vs. Supportive

Manipulative

Non-Manipulative

- Exclude complications
- Manage pain
- Educate patient and parents
- Follow-up as needed



Cannot code initial cast/splint application with global fracture care – can code replacement casts

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Fracture Care or E/M?

- Can code E&M with initial fracture care
- Two choices for coding non-manipulative fractures – either is correct
  - Fracture care – 90 day global – cannot code for followup visits
  - E&Ms for every visit, cast/splint application
- Can always code for xrays and casting supplies

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Removal of Foreign Body

Skin – incision and removal – subcu –
simple – 10120
complicated - 10121
No incision? – E&M service

Ear – external auditory canal – 69200
(old ventilating tube not considered FB)

Eye – conjunctival superficial – 65205
conjunctival embedded – 65210

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Nebulizer Treatment

94640

- Code for medication separately but use of nebulizer is included in code
- May bill for multiple treatments on the same day with modifier –76 on subsequent treatments
- Documentation should include O2 sats and lung sounds before and after treatment along with name and credentials of person administering

Also consider 94664 - Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device - but not both on same day

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Office Visit with Procedures

- Modifier 25 - Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of Procedure or Other Service
- Beyond the usual preop and postop care
- Different diagnosis is not required
- The decision to perform the procedure is part of the procedure code
- Be sure to check global periods on minor procedures

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Separate OV with Procedure?

She is here for F/U of cerumen impaction. She had B/L cerumen impaction with decreased hearing in L ear last week. Her ears were irrigated with success on R side, but was unsuccessful on L due to wax being too hard to break apart, even with physician instrumentation. She was sent home on regimen of softening wax and warm water every evening and returns today to retry cerumen removal on L side.

ROS

ROS as noted in the HPI

Physical Exam

Patient is a 15-year-old female.

General Appearance: General: well-developed, no acute distress, and **morbidly obese**; **obese and is also "big boned".**

Ears, Nose, Throat: Ears: tympanic membranes pearly w/ good landmarks; **after cerumen removal.**

Cardiovascular: Apical impulse: not displaced. Rate and rhythm: regular. Heart Sounds: normal S1, S2, and femoral pulse; no murmur, gallops, or rub. and pedal pulses intact.

Lungs: Auscultation: no wheezing, rales/crackles, rhonchi, tachypnea, or retractions and clear to auscultation. Percussion: no dullness, hyperresonance, or tympany and normal.

Procedure Documentation

Cerumen Removal:
Patient is here for ear wax removal. The left ear was irrigated with complete removal of the cerumen. Pt tolerated procedure well. No complications. Ear canal(s) clear.

Assessment / Plan

1. Impacted cerumen in left ear - She is here for F/U of cerumen impaction. She had B/L cerumen impaction with decreased hearing in L ear last week. Her ears were irrigated with success on R side, but was unsuccessful on L due to wax being too hard to break apart, even with physician instrumentation. She was sent home on regimen of softening wax and warm water every evening. Her left ear was irrigated successfully with improvement in hearing. Rec abstaining from q/tips and rinse with warm water regularly.
H91.22: Impacted cerumen, left ear

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Diagnosis Coding Concerns for Pediatrics

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Obesity

- E66.01 Morbid (severe) obesity due to excess calories
- E66.09 Other obesity due to excess calories
- E66.1 Drug-induced obesity
  Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)
- E66.2 Morbid (severe) obesity with alveolar hypoventilation
- E66.3 Overweight
- E66.8 Other obesity
- E66.9 Obesity, unspecified

Also code BMI if documented - can be documented by staff

Diagnosis coding guidelines are that the BMI is not coded without the E-code as above BUT some payers require it.

Note that E-code cannot be extrapolated from BMI – the physician must specifically state the clinical diagnosis.

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BMI - Pediatric

- Z68.51 Body mass index (BMI) pediatric, less than 5th percentile for age
- Z68.52 Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age
- Z68.53 Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age
- Z68.54 Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age

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ADHD in ICD-10-CM

F90.0 – predominantly inattentive type
F90.1 – predominantly hyperactive type
F90.2 – combined type
F90.8 – other type

Code separately for anxiety, mood disorders, developmental disorders

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Symptoms, Signs and other Abnormal Clinical Findings

Code symptoms when:

- No more specific diagnosis can be made even after all facts have been investigated
- Provisional diagnosis in patient failing to return
- Referred elsewhere before diagnosis made
- More precise diagnosis not available

Do not code symptoms when the cause is known and coded.

Exception: Certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right

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Injuries - 7th Characters – Episode of Care

- Initial encounter
  the patient is receiving active treatment for the condition. Examples: surgical treatment, emergency department encounter, and evaluation and **continuing treatment by the same or a different** physician.
- Subsequent encounter
  after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples: cast change or removal, **an x-ray to check healing status of fracture**, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.
- Sequela
  Complications or conditions that arise as a direct result of a condition ("late effects")
  - Use both the injury code that precipitated sequela and code for sequela – code for sequela first
  - S added only to injury code, not sequela code

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Underdosing

Codes for caregiver noncompliance

- Z91.A20 – Caregiver's intentional underdosing due to financial hardship
- Z91.A28 – Caregiver's intentional underdosing due to other reason

Example –

Patient returns for followup 2 weeks after visit for ear infection, where a prescription for Amoxicillin was given. Mom states that the patient got better then worse again. Upon questioning, she admits that she stopped the antibiotic after 5 days because the patient seemed better.

H66.90 - Otitis media, unspecified, unspecified ear

T36.0X6A - Underdosing of penicillins, initial encounter

Z91.A28 - Caregiver's intentional underdosing of medication regimen for other reason

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Drug Therapy

- Z79.1 - Long term (current) use of non-steroidal anti-inflammatories (NSAID)
- Z79.2 - Long term (current) use of antibiotics
- Z79.51 - Long term (current) use of inhaled steroids
- Z79.52 - Long term (current) use of systemic steroids
- Z79.82 - Long term (current) use of aspirin
- Z79.899 - Other long term (current) drug therapy

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Resources

- https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf
- https://www.aap.org/en/practice-management/child-health-finance-payment-strategy/coding-and-valuation/evaluation-and-management/
- https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf

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Questions?

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