

# PEDIATRIC CODING ALERT

The practical adviser for ethically optimizing coding reimbursement and efficiency for pediatric practices

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## Avoid 99173 Bundles by Offering Readily Paid VEP Vision Testing

► ***This amblyopia screening tool has its own code***

If you want to test nonverbal patients for visual impairments, you may want to consider a visual evoked potentials machine that insurers often cover per test from a low of \$30 to a high of \$160.

Although payment for vision screening (99173, *Screening test of visual acuity, quantitative, bilateral*) can prove hard to come by, reimbursement is much more straightforward for VEP test code 95930 (*Visual evoked potential [VEP] testing central nervous system, checkerboard or flash*). Instead of the SureSight Vision Screener (99173), "I use the VEP machine (95930)," says **Richard Lander, MD, FAAP**, a pediatrician at Essex-Morris Pediatric Group in Livingston, N.J. "It is a good screening test for amblyopia that is able to test kids as young as 6 months old."

## Test Nonverbal Children With Staff-Run Test

The American Academy of Pediatrics Bright Futures evidence-based age-specific guidelines recommend that children have an early childhood vision screen at age 3 or 4 years. And the U.S. Preventive Task Force, an independent panel of experts in primary care and prevention that reviews the evidence of effectiveness and develops recommendations for clinical preventive services, recommends screening to detect amblyopia, strabismus and visual acuity defects in children younger than 5 years of age.

**Benefit:** A VEP machine, such as the *Enfant Pediatric Vision Testing System* manufactured by Diopsys, lets you detect visual deficits, such as optic nerve disorders, asymmetric refractive errors, and other problems that could lead to amblyopia in children who can't tell they have visual problems.

The child may be preverbal or unreliably tested with subjective vision tests, says **Diane C. Fulton**, director of insurance/medical coding and billing for Diopsys Inc. in Pine Brook, N.J. Or with older children, the patient may not recognize that he has a problem because his sight seems "normal" to him.

VEP testing provides the doctor with an objective assessment of a child's vision for appropriate referral, diagnosis and treatment. "It's just not practical to send every child to a specialist for a test that the patient's pediatrician can do," Fulton says. "This test makes a difference in children's lives by catching vision problems that could affect their development at a time when they are most receptive to treatment."

**Easy:** A physician extender can run the test, which has Federal Drug Administration approval for children ages 6 months to 8 years. The machine requires no technical certification. Diopsys provides complete training on the test's use.

## Expect Payment Most of the Time

CPT contains 95930 for VEP. Insurers reimburse the test 80 percent of the time, depending on your payer mix and geographic area, Fulton says.

The estimated 20 percent of payers that reject 95930 coverage usually do so due to contractual issues. "The insurer doesn't want to add the code to its capitation exceptions," Fulton says. "Or, the payer requires a specialist perform the test based on antiquated intra-operative VEP guidelines."

## Check Your Payers' Rates

Medicare allows \$108 (2.83 relative value units) for 95930 nationally. Therefore, for example from payers that pay 120 percent of the 2008 fee schedule, you can expect about \$129. Insurers and Medicaid programs offer a wide range of 95930 payments.

Commercial plan payments range from \$60 to \$160. "Aetna sets the 'gold standard' of medical policies when it comes to VEP," Fulton says. The insurer recognizes the importance of early vision testing during a well check.

Most state Medicaid plans cover VEP. Ohio Medicaid pays the code at a low of \$30, with many other state Medicaid plans paying about \$90.

## Challenge OR Coverage Limitations

Some plans may have outdated VEP policies. For instance, Oxford's guidelines limit VEP coverage to the operating room or certain specialists. Surgeons often use VEP to monitor brain function when performing delicate operations close to the optic nerve. Some insurers need to update their policies to reflect the new use of VEP machines in primary care, Fulton says.

**Action:** Make a chart of your major payers' VEP policies focusing on noncovered versus covered. Fulton follows VEP reimbursement trends across the country and can help facilitate this process (dfulton@diopsys.com or 973-244-0622 ext 322). "If an insurer states it is not a covered service, the patient has the option to pay at the time of service," Lander says.

**Condition defined:** In amblyopia, the visual cortex's response to visual images becomes impaired because the patient's visual pathway has been affected. A VEP machine functions like a "mini" (three-lead) EEG by analyzing the visual EEG component and comparing each eye's function.

This results in a readable analysis that identifies any asymmetries from the front of the eye to the visual cortex. This differs from photoscreening (99174, *Ocular photoscreening with interpretation and report, bilateral*) or retina mapping because VEP records the optic nerve's function to the brain.

### CONTACT INFORMATION

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## Hold Off on Related Supplies

Although 95930's practice expense does not include the eye patch (A6411), payers generally don't cover the item.

Code 95930's Medicare fee schedule practice expense relative value units include the electrodes

(A4556) and the conductive gel (A4558) associated with the test, says **Richard Tuck, MD, FAAP**, a prior member of the AMA's Specialty Society Relative Value Scale Update Committee.

Payers that follow the fee schedule may justifiably deny this additional charge as included in the payment for 95930. □

## Get Paid for 95930 During E/M Using 2 ICD-9 Tips

### ► Watch out: Sometimes a well-check diagnosis isn't the way to go

You'll get paid the first time around for VEP tests if you use the payer-required V code and switch to a problem code when you should.

#### 1. Track V Code Requirements

Because physicians often perform VEP during a preventive medicine service, you'll link 95930 (*Visual evoked potential [VEP] testing central nervous system, checkerboard or flash*) to one of two V codes. On your VEP tracking sheet, note a payer's ICD-9 requirement of either of these:

- V20.2 — *Routine infant or child health check*
- V80.2 — *Special screening for neurological, eye conditions.*

Most insurers cover the test during the well check with the preventive medicine service diagnosis. "Many commercial plans, as well as Aetna, accept V20.2 on the vision screening and on the preventive medicine service," says **Diane C. Fulton**, director of insurance/medical coding and billing for Diopsys Inc. in Pine Brook, N.J.

"Technically, V80.2 is a better code to use with 95930 because the specific V code describes why the provider is doing the procedure," Fulton says. Some health plans bundle screenings codes with V20.2. Therefore, a different ICD-9 code from the preventive medicine service's V code (V20.2) will show that the screening is a separate and identifiable procedure from the well visit (99381-99385 for new patients, and 99391-99395 for established patients).

**Example:** At a 3-year-old's established patient preventive medicine service, the pediatrician orders a nurse to test the child's vision using the VEP machine. The test shows the child has no functional asymmetries. On the claim, you report:

- 99392 (*Periodic comprehensive preventive medicine reevaluation and management of an individual ... early childhood [age 1 through 4 years]*) for the preventive medicine service

- 95930 for the VEP test
- V20.2 linked to 99392
- V80.2 linked to 95930 (V20.2 for Aetna).

#### 2. Default to Problem Diagnosis When Found

Make sure you use the V code only when the screening is negative. When the test reveals a problem, switch to the problem diagnosis.

**Example:** A mother brings in her 6-year-old son. She's worried he may have learning disabilities because his teacher says he's not reading at the same level as his peers. A nurse administers a Conner's developmental test (96110, *Developmental testing; limited [e.g., Developmental Screening Test II, Early Language Milestone Screen], with interpretation and report*) that the pediatrician interprets as showing no problems. The pediatrician then has a nurse screen the child's vision with the VEP machine. The test shows a positive result: There are differences in each eye's response. The pediatrician reports a level-four office visit, which the coder enters on the CMS-1500 form with:

- Dx 1 V71.89 (*Observation and evaluation for other specified suspected conditions*)
- Dx 2 315.00 (*Developmental reading disorder, unspecified*)
- Dx 3 794.13 (*Abnormal VEP*).

#### Procedure, Services

1. 99214 (office visit)
2. 96110 (Conner's test)
3. 95930

#### Diagnosis Pointer

- 1, 2
- 1, 2
- 3.

**Note:** To indicate an unfound condition, such as delayed reading not found, the American Academy of Pediatrics recommends listing the V code first. Payers, however, may deny V71.89 as a primary diagnosis.

If the child tested normal (negative), you would bill 95930 with the condition, sign or symptom that prompted the test and V80.2. □

## Case Study:

# Try 4 Strategies to Deter 90472 Duplication Denials

## ► These forms reveal legit multiple-IA billing methods

When faced with rejections for multiple shot administrations, try vaccine diagnoses, a one-line entry or a last-resort modifier.

“We have recently begun billing for +90472 (*Immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; each additional vaccine [single or combination vaccine/toxoid [list separately in addition to code for primary procedure]*),” writes **Peg McCarthy**, accounts receivable supervisor for Pediatric Health Association in Naperville, Ill. Payers are rejecting the code as duplicates.

If the same problem plagues you, apply one of four techniques illustrated in this case study:

At an 11-year-old established patient’s preventive medicine service (99393, *Periodic comprehensive preventive medicine reevaluation and management of an individual ... late childhood [age 5 through 11 years]; V20.2, Routine infant or child health check*), a nurse administers three vaccines, which include:

- DTaP — 90715, *Tetanus, diphtheria toxoids and acellular pertussis vaccine, when administered to individuals 7 years or older, for intramuscular use; V06.1, Need for prophylactic vaccination; diphtheria-tetanus-pertussis, combined (DTP) (DTaP)*

- MCV4 — 90734, *Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use; V03.89, Need for prophylactic vaccination and inoculation against bacterial diseases; other specified vaccination*

- a catch-up MMR — 90707, *Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use; V06.4, Need for prophylactic vaccination; measles-mumps-rubella (mmr).*

### 1. Match Your Product, Admin Diagnoses

To show insurers that each 90472 is for a different product, use the same ICD-9 code that you use with the vaccine product with the administration code, said **Joel Bradley, MD, FAAP**, in “Stop Losing CASH NOW:

Beat the Challenges of Vaccines Coding Today” at *The Coding Institute’s Pediatric Coding and Reimbursement Conference 2007* in Naples, Fla. Using this technique, you would enter the above case study on a CMS form as follows:

Box 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

- |          |           |
|----------|-----------|
| 1. V20.2 | 3. V03.89 |
| 2. V06.1 | 4. V06.4  |

24	D	E	G
	PROCEDURES, SERVICES	DIAGNOSIS POINTER	DAYS OR UNITS
1.	99393	1	
2.	90715	2	
3.	90471	2	
4.	90734	3	
5.	90472	3	
6.	90707	4	
7.	90472	4	

### 2. Switch to V20.2 for Limitations

You may face restrictions, however, on how many diagnoses you can list. “Our system allows only two diagnoses,” says **Barbara Morgan** in North Carolina. When she has several immunizations to report using 90472, she can’t list all applicable ICD-9 codes.

**Solution:** Although itemizing each diagnosis is optimal coding, lumping multiple 90472s under V20.2 is also OK, Bradley says. “You can use V20.2 for all vaccines given during a preventive medicine encounter.”

## You Be the Coder

### E/M or Nosebleed Code?

**Question:** *A mother brought in her teenage son who had collided with another player in a soccer game. He had a bleeding nose that she couldn’t stop from bleeding after two hours. The pediatrician applies a nitrogen stick to the bleeding site. Should I report an office visit code for the bleeding control?*

Massachusetts Subscriber

**Answer:** See page 47 for the answer. □

Using this strategy would change the above claim to read:

Box 21. DIAGNOSIS

1. V20.2

24	D	E
	PROCEDURES	DIAGNOSIS POINTER
1.	99393	1
2.	90715	1
3.	90471	1
4.	90734	1
5.	90472	1
6.	90707	1
7.	90472	1

**Future:** When your system restricts the number of diagnoses you can report, you're going to have to find a long-term remedy. If your billing system won't take more than one diagnosis, you need another vendor, says **Nancy Reading RN, BS, CPC, CPC-I**, vice president of educational services for the American Academy of Professional Coders in Salt Lake City.

### 3. Use Units With 90472

If line limitations cause your billing software to split a claim involving multiple 90472s, the insurer may receive a claim for 90472 that omits the required initial vaccine administration code, such as 90471 (*Immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; one vaccine [single or combination vaccine/toxoid]*). To avoid this, bill multiple units of service on one line for this 90472 procedure code related to the number of vaccine injections provided, Blue Cross BlueShield of Texas says.

Using V20.2 for all vaccine diagnoses would change lines five through seven in the above claim to read:

24	D	E	G
	PROCEDURES, SERVICES	DIAGNOSIS POINTER	DAYS OR UNITS
5.	90472	1	1
6.	90707	1	

**Beware:** Although CPT places no maximum units on 90472, some insurers impose a frequency limit. For physician-purchased vaccines, Washington state's Health and Recovery Services Administration pays only two vaccine administrations. Therefore, HRSA limits 90472 to one unit.

### 4. Show Separate Site

When reporting multiple 90472s, rule out using modifier 76 (*Repeat procedure or service by same physician*). The modifier represents a procedure that the physician "repeated subsequent to the original procedure," according to CPT 2008 Appendix A — Modifiers.

For insurers that deny multiple 90472s, a better modifier is 59 (*Distinct procedural service*), says **Richard Tuck, MD, FAAP**, a practicing pediatrician with PrimeCare Partners in Zanesville, Ohio. "In addition to the product being different, the injection site — for instance, intradermal or intramuscular — could be different as well."

You could use modifier 59 on subsequent 90472s. If you assign specific vaccine diagnoses, your claim could contain these items:

Box 21. DIAGNOSIS

- |          |           |
|----------|-----------|
| 1. V20.2 | 3. V03.89 |
| 2. V06.1 | 4. V06.4  |

24	D	E
	PROCEDURES, SERVICES	MODIFIER DIAGNOSIS POINTER
1.	99393	1
2.	90715	2
3.	90471	2
4.	90734	3
5.	90472	3
6.	90707	4
7.	90472	59 4

For more strategies, join fellow coders and pediatricians at the 2008 Pediatric Coding and Reimbursement Conference on May 15-17 in Naples, Fla., or on July 10-12 in Las Vegas. Register at [codingconferences.com](http://codingconferences.com). □

#### Get Paid for 'Bright Futures' Services and Phone Care With These Moves

You'll be on the fast track to proper payment when you join pediatric experts for these upcoming audioconferences:

- **Capture All "Bright Futures" Services** on Tues., June 3, at 1 pm ET, presented by Jennifer Godreau, BA, CPC
- **Must-Have Nuts 'n' Bolts of Pediatric Billing** on Wed., June 4, at 1 pm ET, given by Donelle Holle, RN
- **Telephone Call Nuances: Coding, Billing, Getting Paid** on Thurs., June 5, at 1 pm ET, with Charles Scott, MD, FAAP.

To register, go to [audioeducator.com](http://audioeducator.com) and search for "pediatric."

## READER QUESTIONS

### Should We Apply CCI Across the Board?

**Question:** *We are a large multispecialty group. Some coders who file Medicare claims suggest that we always code based on the Correct Coding Initiative (CCI) edits. Since we report claims to private payers only, we have been following CPT guidelines. Who is right?*

Missouri Subscriber

**Answer:** Before deciding who is “right,” consider a few factors.

**1. The hierarchy.** The AMA creates current procedural terminology (CPT) guidelines, which appear in the CPT manual. Medicare implements these guidelines in the form of quarterly CCI edits. CCI’s code pairs can affect how you use CPT codes and can create coding conflicts. The CCI edits do not necessarily reflect AMA’s CPT rules.

You would have to follow Medicare rules if you were coding for a Medicare carrier as your peers who bill beneficiary services do. But because pediatric practices don’t bill Medicare, they do not have to adhere to CMS’ stricter guidelines.

Think of it another way. ICD-9 guidelines have instructions that private payers sometimes do not follow. For instance, when sequencing codes for a follow-up otitis media encounter during which the provider no longer finds OM, the optimal ICD-9 answer is V71.89 (*Unfound condition*). But most payers also want you to list the condition that is no longer present — the OM, such as 381.1x. Here, although you should follow ICD-9 guidelines, you must adhere to the method the payer requires.

**2. Payment.** Some consultants recommend applying Medicare’s stricter guidelines to all payers for compliance reasons. Other experts, however, suggest coding per insurer to obtain the maximum ethically allowed pay.

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### How to Make a Time Note Audit-Friendly

**Question:** *When coding based on time, my pediatricians document the amount of time they spend with a patient. Does a note, such as “Spent 25 min seeing this patient,” suffice?*

Ohio Subscriber

**Answer:** No, documentation that supports coding a visit using time as the controlling factor must show the percentage of time that was spent face-to-face with the

patient on counseling and/or coordination of care versus the total visit. For a visit to qualify for time-based outpatient coding, the counseling must comprise more than 50 percent of the face-to-face encounter.

For instance, the physician could write, “Spent 25 min total face-to-face time/15 minutes counseling.” This note clearly shows an auditor that the visit supports time-based coding.

**Don’t miss:** Chart reviewers will want some brief description of what the physician reviewed and provided. Therefore, you should encourage your pediatricians to indicate two items:

1. the counseling/and or coordination of care topic, such as discipline, biting avoidance
2. a general reference to the counseling/coordination of care provided, such as discussed parental concerns, treatment options, follow-up.

---

### Antibiotic Doesn’t Cinch 99214

**Question:** *The risk management table lists prescription drug management as moderate risk. Does this mean I can code 99214 when an encounter requires an antibiotic?*

Colorado Subscriber

**Answer:** Prescribing an antibiotic does not automatically mean you should code a level-four E/M service (99214, *Office or other outpatient visit for the E/M of an established patient that requires two of these three key components: a detailed history, a detailed examination and medical decision-making of moderate complexity. Physicians typically spend 25 minutes with the patient*).

The table, which CMS includes in the E/M Documentation Guidelines, means that the risk associated with a patient who requires antibiotic treatment may be at the moderate level or near it.

**Key:** Medical necessity must guide the elements that the pediatrician performs and documents. For instance, the following note supports 99214.

- CC: Fever and vomiting
- HPI: Congestion and wet cough for four days, Temp to 103 for two days, Vomiting 2x today; Irritable with poor feeding, sleeping
- PFSx: Hx otitis x 3 in past 6 mos; Fhs others ill resp illness
- Shx: Parents smoke
- PE: temp 102.5, RR 24, Wt 22lbs
- Fussy but responsive; skin flushed, turgor good; TM’s erythematous, bulging; pharynx mod erythema; neck supple; chest clear to auscultation; heart reg rhythm

without murmur; abdomen soft, without masses, tenderness; neuro irritable but responsive

- Impression: Otitis media, recurrent; vomiting; fever
- Rx: Amoxicillin, Tylenol, clear fluids with diet advanced as tolerated; discussed in detail including parents' concerns with recurrent ear infections
- F/U ear recheck in 2 to 3 weeks.

The chart includes these 99214 qualifying elements:

- five history of present illness (HPI)
- three past, family and social history (PFSH)
- eight review of systems (ROS).

With an additional two ROS and one PFSH, the visit could have qualified as 99215, which requires four elements of HPI, 10 ROS elements and two of three PFSH elements. Alternatively, if the pediatrician had spent more than 20 minutes of a 40-minute visit counseling the parents on possible surgery and hearing loss concerns, he may have coded 99215 based on time.

For the diagnoses, you would code acute otitis media (382.00), vomiting (such as 787.03, *Vomiting alone*) and fever (780.6). OM with systemic symptoms noted supports the medical necessity of 99214 for this visit.

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### Treat Special Service Codes as Add-Ons

**Question:** *Do we need to use a modifier when coding prolonged services or special services?*

Illinois Subscriber

**Answer:** No. These codes are add-on codes that you report in addition to the E/M code without a modifier.

**Example:** At an ob-gyn's request, a pediatrician attends an emergency cesarean delivery that occurs at midnight. The pediatrician examines the newborn and admits her to the hospital. You can code on the claim:

- the attendance at delivery with 99436 (*Attendance at delivery [when requested by delivering physician] and initial stabilization of newborn*)
- the after-hours hospital services as 99053 (*Service[s] provided 10 pm to 8 am at 24-hour facility*)
- initial hospital care with 99221-99223 (*Initial hospital care, per day, for the evaluation and management of a patient ...*).

**Note:** CPT does not require modifier 25 (*Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service*) on 9922x with 99436. But when you report this code combination, payers may require modifier 25 on 9922x to

indicate the hospital care (9922x-25) is a significant, separate service from the attendance at delivery (99436).

Similarly, you would not need a modifier to report a prolonged service. For instance, if a pediatrician spends 70 minutes face-to-face with a patient on a 99215 encounter, you would report 99215 (*Office or other outpatient visit for the E/M of an established patient ... Physicians typically spend 40 minutes with the patient*) and +99354 (*Prolonged physician service in the office or other outpatient setting requiring direct [face-to-face] patient contact beyond the usual service [e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting]; first hour [list separately in addition to code for office or other outpatient evaluation and management service]*).

The first prolonged service code requires a minimum of 30 minutes beyond the time CPT indicates that physicians typically spend on the coded service — 40 minutes for 99215.

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(Continued on next page)

## You Be the Coder

### E/M or Nosebleed Code?

**Answer:** Because the pediatrician used cauterization to control the bleeding, report 30901 (*Control nasal hemorrhage, anterior, simple [limited cautery and/or packing] any method*), which pays more (2.64 relative value units) than all established patient office visits except 99215 (3.43 RVUs). But if the physician used only pressure to control the nosebleed, and no kind of cauterization, you would code only the office visit. Link the nosebleed control to epistaxis (784.7).

If the pediatrician performs a significant and separate E/M service from the minor E/M included in 30901, such as evaluating associated head trauma, you may also report the office visit (99201-99215) appended with modifier 25 (*Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service*).

On claims containing an E/M-25 service and 30901, you may want to also report 99058 (*Service[s] provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service*). Code 99058 is appropriate if the triage nurse considered the patient an emergency that required disrupting the physician's scheduled appointments. □

## Article Provides Ammo for 9944x Coverage

**Question:** *A pediatrician talked to a mom who called in because her toddler's gum was stuck between her front teeth after a fall. We initially charged a telephone care code because the mother was able to stop the bleeding. But the child kept crying, so the mother brought her in that afternoon, and we billed an office visit. Can I still report the call code?*

Florida Subscriber

**Answer:** No, "if the telephone service ends with a decision to see the patient within 24 hours or the next available urgent visit appointment," you should not report the telephone service code, according to "Coding Communication: Non-Face-to-Face Physician Services: Telephone Services" in *CPT Assistant* March 2008. You would instead code only the office visit (99212-99215, *Office or other outpatient visit ...*).

Although the recently released AMA article delineates the same rules outlined in CPT 2008 for telephone care codes (99441-99443), you may want to reference the article during insurer coverage negotiations. The article further states: "Telephone services expand healthcare access for patients who may not need or are unable to come to a physician's office. These services can also make available advice and care to those who might otherwise seek more expensive care in an urgent care center or overcrowded emergency department, and offer a solution in helping to decrease healthcare costs by providing an alternative to more costly face-to-face services."

— *Answers to You Be the Coder and Reader Questions provided/reviewed by Barbara J. Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC, president of CRN Healthcare Solutions in Tinton Falls, N.J.; Donelle Holle, RN, a pediatric coding and auditing consultant; Richard Lander, MD, FAAP, Essex-Morris Pediatric Group in Livingston, N.J.; Peter Rappo, MD, FAAP, a pediatrician and clinical professor of pediatrics at Harvard Medical School in Boston; Richard H. Tuck, MD, FAAP, pediatrician at PrimeCare of Southeastern Ohio in Zanesville.* □

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