MEDICAL BILLING AND DOCUMENTATION

A PRACTICAL HANDBOOK

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CHAPTER 1- SUPPORT, LAYOUT, AND RESOURCES

I started my first day on service in the ICU with zero education on billing and documentation, which is typical for most physicians. My ICU chief spent 5 minutes explaining which codes to circle on a standardized coding sheet. The lack of proper education made billing and documentation quite stressful for me until I read more about it. I hope you feel more prepared on your first day as an attending and feel comfortable selecting different CPT codes.

Billing is not rocket science. If you allocate the same amount of reading time to billing as you do for any other medical topic, then there is no reason that you will not be an expert on it. Chapter 2 will probably be the most difficult, as it involves details of medical decision-making. A good understanding of medical decision-making takes a little time. Other chapters are straightforward. The last 2 chapters are intended for use during the real-life code selection process. Relevant code tables are listed in chapter 13 and, diagrams in chapter 14 show how these codes are selected. If you carry these chapters in your phone and refer to them when you need, it would help with many billing and documentation questions.

If you ever have any questions on billing and documentation or feedback about the material, please send an email to my personal email at eyupmd@gmail.com

Resources that may help,

1- www.medicalbillingcurriculum.com I created this website. It is an online course that can contains my video lectures, reading material and quizzes.
2- CPT codebook. Every year, there is a new CPT code book with mostly the same codes. It is a good idea to have one for reference. If you work in an institutional setting, the billing department would love to give you a free copy. Just ask.
3- AAP coding for pediatrics is also a great resource.
4- The CMS physician fee schedule is a tool to see the RVU units of each code https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files/rvu25c
5- This link provides the CPT codes covered by MediCal along with reimbursement rates. https://mcweb.apps.prd.cammis.medi-cal.ca.gov/rates?tab=rates
6- https://www.cgsmedicare.com/medicare_dynamic/j15/ptpb/ptp/ptp.aspx This website is great for looking at mutually exclusive code pairs.
7- eyupmd@gmail.com I am always available and happy to help if you have any billing and documentation related questions.

CHAPTER 2-INTRODUCTION TO MEDICAL BILLING AND DOCUMENTATION

1-BIG PICTURE

Medical billing and documentation is included in one of the six competencies of ACGME, specifically within the system-based practice core competency. Despite this, it is rare for a physician to receive formal education in billing and medical documentation during residency or medical school. As a result, most attendings start their first day at the job virtually unprepared for medical billing and documentation and learn it from their colleagues along the way.

Appropriate billing and documentation is not only key to a successful private practice but also important for revenue generation in academic settings and for keeping physicians out of legal trouble.

4 different code sets are used in the healthcare system. These are ICD, CPT, HCPCS, and NDC codes. Our focus will be mostly on CPT codes. ICD codes are used for diagnosis or the reason for encounter. CPT codes are used for most professional services, vaccines, and immune globulins. HCPCS codes are used for supplies, durable medical equipment, and medications. HCPCS codes are also used for professional services when an appropriate CPT code is not available. HCPCS codes are typically used by facilities and are not further covered, as they are not frequently used by physicians. National Drug Codes (NDCs) are used for specific prescription drugs, vaccines, or insulin products. An example for each code category is given below.

CPT: 92950: Cardiopulmonary resuscitation.

ICD-10-CM: J02.0: Streptococcal pharyngitis

HCPCS: J0171: Injection, adrenalin, epinephrine 0.1mg or S06630: removal of sutures, by a physician other than the physician who originally closed the wound

NDC: 60574-4114-01: Synagis 0.5mli 1 vial, single dose

2- CPT CODES

CPT codes serve as a standardized language that replaces lengthy descriptions of medical care with concise five-digit numbers. This system streamlines communication with payers and simplifies claims processing across a wide range of services.

CPT is owned and maintained by the American Medical Association. The first edition of CPT was published in 1966. CMS's recognition of CPT as a standard coding tool in 1983 led to widespread acceptance of these codes. Initially, use of CPT codes was voluntary, but with the implementation of the 1996 HIPAA, their use for transactions involving health care information became mandatory. Today, the CPT coding system is the main system for describing healthcare services in the USA. CPT codes are updated annually by the AMA, and each year a new CPT code book is published, with mostly minor changes.

A CPT code is a 5-digit number with values ranging from 1 (00001) to 99999. Although one 100 thousand codes are possible, only around 11 thousand codes exist. CPT codes can be divided into 6 major groups in numerical sequence

1-Anesthesia

2-Surgey

3-Radiology

4-Pathology/Laboratory

5-Medicine

6-Evaluation and Management

Classification of codes into the major groups doesn't follow a set rule but is mostly based on historical usage. Surgical codes are not reserved for surgeons, and the medicine codes are not reserved for internists. For example, coronary angiography and stent placement is under medicine likely because these procedures are exclusively done by cardiologists, but many other angiographic procedures are listed under surgery. Most ultrasound studies are listed under radiology, but ultrasound of cranial vessels and duplex scan of veins for DVT are under medicine. Surgery contains many CPT codes that are used by non-surgical physicians, such as endoscopy and intubation. Most endoscopic studies are listed under surgery, but *nasopharyngoscopy with an endoscope* is listed under medicine, and this procedure is typically performed by ENT surgeons in the office setting. Although all central line placement procedures, including PICC line placement, are under surgery, Swan-Ganz catheter insertion, a more invasive procedure, is under medicine. Qualifying circumstances for anesthesia and moderate sedation are under medicine, while local anesthesia is under surgery.

CPT codes can be divided into ten-thousand blocks, which often match major groups. Paying attention to these sequences and sections helps you see the big picture and find the needed code more easily.

Now, let's look at each code group in more detail. We begin with anesthesia codes, which include the first 10 thousand, starting with either 00 or 01. Anesthesia codes are divided according to body region/organs.

Codes starting with 00: Anesthesia for head, neck, thorax, spine, Abdomen, Perineum

Codes starting with 01: Anesthesia for pelvis, extremities, radiological procedures, burn, and obstetric.

Any CPT code that starts with either 00 or 01 is an anesthesia code.

Surgery Codes: This group includes codes starting with 10 thousand to 60 thousand. Surgery codes are also divided by body region or organ. Any CPT code that starts with 1, 2, 3, 4, 5, or 6 is a surgery code.

10 thousand series: Skin, Breast procedures

20 thousand series: Musculoskeletal procedures

30 thousand series: Respiratory, cardiovascular, hematology, lymphatic system procedures

40 thousand series: Digestive system procedures

50 thousand series: Urinary, male/female genital system, maternity procedures

60 thousand series: Nervous system, eye, auditory, endocrine system procedures

Many codes in these sections are used by pediatricians, such as I&D, freezing warts, intubation, central/arterial line placements, endoscopy/bronchoscopy, circumcision, and LP.

Radiology codes (including nuclear medicine and ultrasound): This group includes codes starting with 70 thousand. Most are reported by radiologists. Any CPT code that starts with 7 (70 thousand series) is a radiological procedure.

Pathology/Laboratory: This group includes codes starting with 80 thousand. Any CPT code that starts with 8 (80 thousand series) is a pathology/laboratory procedure. In office settings, physicians can report these codes, but in inpatient settings, hospitals report them. For example, an office physician may use the code 81000 to report urinalysis performed in the office or code 87807 for a rapid RSV test.

Medicine codes: This group includes codes starting with 90 thousand. Any CPT code that starts with 9 (90 thousand series) is a medicine procedure except evaluation and management codes. There are multiple subgroups under the medicine codes. CPT codes for vaccines and vaccine administration codes are under this section

Evaluation and management (E/M) codes: This group is the only group that is not in numerical sequence. Except for newly added telemedicine codes, this group starts with 99 thousand (99202-99499), and there are medicine codes before and after evaluation and management codes. This code group applies to the evaluation and management of patients and is among the most commonly used codes by physicians across specialities and other health care workers. All sick office visits and well-child checks, inpatient admissions, follow-up/discharge care, consultations, and critical care codes are under this section.

In addition to E/M codes, which all physicians use, CPT codes a physician needs depend on their specialty. For example, gastroenterologists need to learn endoscopy codes, while intensivists need intubation and central line placement codes. Physicians should review the CPT codebook's sections and pages to find the codes relevant to their own practice.

Code descriptor

After finding the code number you are looking for, it is a good idea to look at the code descriptor. Every CPT code has a description attached next to it. Some CPT codes, like 99950, have very brief descriptions; hence, they have no specific usage or documentation requirements.

99950: cardiopulmonary resuscitation *(that is all the descriptor says).* Notice how brief the description of this code is. The code descriptor doesn't list any specific requirements but just gives the procedure name.

Code 99291 is for critical care: evaluation and management of the critically ill or injured patient, for the first 30–74 minutes. The code description is simple and has a few stated requirements. However, a closer look at the CPT book reveals several pages of rules on when and how this code is used.

Some other CPT codes have rather long descriptions and requirements.

99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low-level medical decision making. When using total time on the day of the encounter for code selection, 20 minutes must be met or exceeded.

Notice how more complex the wording/requirements of this code are. In addition to this long description, the CPT code book has several pages explaining the terms used in this code and how to report it.

Take-home message for code descriptor: make sure that you know the code descriptor well and meet its requirements before using the code.

3- ICD CODES

To request reimbursement, a physician must report 2 different codes. The first code is for the diagnosis of the patient's condition, which is reported with an ICD code. The second code is for the procedure or service performed and is reported with a CPT code. So one cannot report a CPT code without an ICD code. ICD codes are used worldwide and are maintained by WHO, whereas CPT codes are used only in the USA.

The first code/ICD tells the payer what brought the patient to the physician in the first place, and the second code/CPT tells the payer what the physician did about this problem.

Example,

Patient had ear pain/infection - - > ICD- - - - > H65.0

I evaluated the patient and prescribed antibiotics - - > CPT- - - > 99213

Selecting an appropriate ICD code is extremely important for the reimbursement process. ICD and CPT codes should align well. The CPT code you selected, which is basically the services or care you provided, should be appropriate for the patient's current problem. If you are billing higher-level E&M codes, then you should select sicker ICD codes. It's recommended that consultants choose different ICD codes from the primary attending to indicate they are managing distinct aspects of patient care.

Examples:

ENT surgeon - - > CPT code for tonsillectomy + ICD code for gastro enteritis - - - > claim will be denied

ENT surgeon - - > CPT code for tonsillectomy + ICD code severe OSA - - - > claim will be accepted

Intensivist - - - > CPT code for critical care + ICD code for knee pain - - - > claim will be denied

Intensivist - - - > CPT code for critical care + ICD code for acute respiratory failure - - - > claim will be accepted

Pediatrician - - - > highest level office CPT code + ICD code for mild URI - - - > claim may be denied

Pediatrician - - - > highest level office CPT code + ICD code for status asthmaticus - - - > claim will be accepted

4-REIMBURSTMENT PROCESS: A COMPLEX INTERPLAY AMONG MULTIPLE AUTHORITIES

Although AMA owns and describes the CPT codes for professional services, other players in the health care industry, which pay for these services, have much to say about these codes as well.

A major player in the healthcare industry is CMS (Center for Medicare and Medicaid Services). Although each payer can develop its own reimbursement regulations, it's the CMS that sets the standards for the rest of the health care industry.

Just because there is a valid CPT code defined by AMA doesn't mean that it's a covered or reimbursed service. Each payer may differ in which services are covered/reimbursed and which are not. On top of this, each payer has its own rules and regulations for reimbursing or denying reported CPT codes.

Some codes are mutually exclusive. Code 99497 (advance care planning) cannot be reported with critical care codes per CPT rules. In addition to mutually exclusive CPT codes described by CPT, payers may have their own list of mutually exclusive code lists, and when a provider reports 2 codes for the same day that are mutually exclusive to that payer, then the software program of the payer automatically denies the claim without even the involvement of a human.

Another important concept is bundle. Some codes, like critical care codes, have a certain list of other CPT codes that are bundled in the critical services by CPT. For example, pediatric critical care codes have a bundle that contains 39 different CPT codes. One of the codes in the bundle is the intubation code, so the CPT code for intubation is not reported separately when pediatric critical care codes are used. All office, inpatient hospital, consultation, and ER codes have no bundle, which means any other CPT codes may be reported separately.

Another important point is the RVU (relative value unit) of a given code. Although AMA owns CPT codes, CMS determines the reimbursement for each code by assigning each code a specific relative value unit (RVU). Other payers typically follow RVUs established by CMS.

Most billing codes are submitted via CMS Form 1500 or a similar form. Form 1500 includes more than 30 fields, including patient demographics, insurance information, charges, diagnoses in ICD codes, and services in CPT codes. This form can be submitted either on paper or electronically, and it can be filled in either automatically by software or manually by a coder. If the physician is using paper-based billing, a coder typically fills out this form manually. If the physician is using an electronic healthcare system like EPIC, EPIC will auto-populate most of the form fields in the second software, which will then send the claim to the payer. In the electronic version, there will still be some limited coder supervision. Like anything else in life, there can be errors when filling out this form; hence, it is important for physicians to know these steps so they can track their bills and ensure their billing codes are sent to payers appropriately.

5- MEDICAL DOCUM ENTATION INVOLVES MORE THAN BILLING

Appropriate medical documentation is essential for reimbursement, but medical documentation or patient note involves much more than billing. Every patient note is a potential medico-legal document, so the more detail you include, the better it is. Most legal cases are brought months, if not years, after the provision of care, so by that time, the physician's memory would not be very useful. The best defense in medical-legal cases is a well-written note that contains enough information. A well-written note is your best friend and your most important tool for protecting your license. So you can write a very short note from the billing perspective, but there are other reasons to consider for writing a longer note, especially for complex cases. Having a neutral tone, avoiding unsupported speculations, describing just the facts, documenting patient or caregivers' comments exactly as it is in quotes, giving a clear timeline of events, documenting your management rationale clearly, and sticking to professional terms and language are of utmost importance when a patient note becomes a medico-legal document.

Patient notes are also among the most important tools for communication among caregivers. A good note is not necessarily a long note. Actually, short, concise notes can be even better than the long notes. So, irrespective of the billing requirements, you may like to add a few more details to note to make it an effective communication tool and protector against potential medico-legal troubles.

CHAPTER 3 – UNDERSTANDING EVALUATION AND MANAGEMENT (E/M) CODES

CPT codes can be practically divided into 2 groups: E/M service codes and the rest (anesthesia, surgery, radiology, pathology/lab, medicine). CPT codes in the second group are only used by a subset of providers. Codes under urology are mostly used by urologists; the code for C-section is exclusively used by obstetricians. In contrast, codes under the E/M section are used daily by all physicians, and this group therefore contains the most commonly used CPT codes. Given their frequent use, these codes are of utmost importance.

E/M service codes typically exist in groups or code sets based on their usage setting. There are code sets for office, ER, hospital floor, and ICU care. Although there are many E/M codes, most physicians need to learn only a handful to report their services.

For practical use, E/M codes can be grouped into MDM based codes and others. Most MDM-based codes also based on time, but we'll refer to them simply as MDM based codes for simplicity. MDM reflects patient complexity: higher MDM means a more complex or sicker patient. These codes have strict rules; you must meet all requirements before using them.

1- MDM-based E/M codes

This group is composed of codes for office, hospital, consult, and ER services.

Let's take a look at CPT code 99213 to better understand an MDM-based code.

99213: *office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.*

This is an MDM-based code because a certain level of MDM was required for its use. The CPT code book has 9 pages that explain the terms used in these codes, including MDM.

Starting in 2022-2023, these codes were significantly simplified to reduce documentation burden. ***Currently, these codes share the same basic structure.*** One example is given for each group.

Office or other outpatient services

New Patient	-	99202	99203	99204	99205
Established Patient	99211	99212	99213	99214	99215

99211 differs from the rest of the office codes and is not an MDM-based code. (*99211: Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional).* There used to be 99201, similar to 99211, but it was deleted several years ago. The rest of the code set is MDM-based. An example of an office code (99213) is given above.

Hospital inpatient and observation care services

Initial	99221	99222	99223
Subsequent	99231	99232	99233

All the codes in this code set are MDM-based. An example of a hospital code is given below.

99233: *Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.*

Consultations

Office/Outpatient- ER	99242	99243	99244	99245
Inpatient/Observation	99252	99253	99254	99255

All the codes in this code set are MDM-based. An example of a consultation code is given below.

99253: In patient or observation consultation for a new or established patient*, which requires a medically appropriate history and/or examination and low level medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.*

Emergency department services

ED services	**99281**	**9982**	**99283**	**99284**	**99285**

99281 differs from the rest of the ER codes and is not an MDM-based code. 99281: Emergency department visit *for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional.* The rest of the code set is MDM-based. An example of an MDM-based ED code is given below.

99284: Emergency department visit *for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level medical decision making.*

These MDM based codes share certain common features.

Place: *specifies the setting for the code: office/other outpatient, hospital inpatient/observation, emergency department*

Usage frequency: *specifies how often a code can be used: per visit, per day. Hospital code 99233 can be used only once per day because the code descriptor states "per day."*

Patient type: *new or established patient. This distinction only applies to office patients. A new patient, as defined by CPT, is a patient who has not been seen by the provider in the last 3 years.*

Care type: *initial or subsequent. Only used in hospital setting.*

A Common similar sentence: *for the evaluation and management of a patient, which requires a medically appropriate history and/or examination*

MDM level: *straightforward, low, moderate, high*

Time/Total time: *required time, only when time is used for code selection. Time is not included in ER codes.*

Except for 99211 and 99281, within each subgroup, the wording of the codes is identical, except for the level of MDM and time. For example, the only difference among the codes 99212-99213-99214-99215 is the level of MDM and the specified time; the rest is exactly the same. For simplicity, some providers

refer to these codes as levels. For example, codes 99212-99213-99214-99215 are called level-2, level-3, level-4, level-5 respectively. The selection of an appropriate level is complex and at times may be a challenge, which will be covered in the coming sections.

There used to be very strict criteria on the required level of history or examination. Because these requirements were a significant burden to clinicians' daily workload, they were removed in 2022/2023. Now, there is no requirement for how much history or examination needs to be documented. Whatever the physician considers medically appropriate is enough. Your claim will not be denied because you haven't documented a specific number of examination or history findings.

2-Non-MDM-based E/M Codes – The rest

The codes in this group are not as complex as MDM-based codes and do not have strict requirements. Examples of the most commonly used non-MDM-based E/M service codes are given below and include preventative care (well child check, WCC), normal newborn care, hospital discharge care, delivery room attendance, and resuscitation care codes. A higher level in well child check code set does not imply a higher level of care or more time, but only means older age group.

Preventative Care/WCC – New Patient	99381	99382	99383	99384
Preventative Care/WCC – Established Patient	99391	99392	99393	99394

Discharge day care < 30 min	99238
Discharge day care > 30 min	99239

Normal newborn care codes	99460	99461	99462	99463

99238: *Hospital inpatient or observation discharge day management. 30 minutes or less on the day of the encounter.*

99391: *Periodic comprehensive preventative medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient, infant (age younger than 1 year)*

99460: *initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant.*

Please note that no MDM level was specified in the above codes; hence, these are non-MDM-based codes with less strict usage requirements. This distinction is important because code selection and medical documentation differ from MDM-based codes. Unlike MDM-based codes, selecting non-DMD codes is a very simple and straightforward process, such as selecting well-child check codes based on patient age alone.

3- RELEVANT E/M SERVICE CODE SETS FOR INDIVIDUAL PHYSICIANS

Most physicians only need to learn a handful of codes, not more. For example, an outpatient physician will never use inpatient codes in the office, and a hospitalist will never use office codes while practicing inpatient. So, although there are thousands of CPT codes, for any given physician, only a handful are relevant, and the rest are irrelevant. This makes learning these codes much easier.

Most commonly used office, outpatient E/M service codes

New Patient	-	99202	99203	99204	99205
Established Patient	99211	99212	99213	99214	99215
Consult - Office	-	99242	99243	99244	99245

Preventative Care/WCC – New Patient	99381	99382	99383	99384
Preventative Care/WCC – Established Patient	99391	99392	99393	99394

Most commonly used inpatient E/M service codes

Initial admission	99221	99222	99223
Subsequent day	99231	99232	99233
Same day	99234	99235	99236

Consult ER	99242	99243	99244	99245
Consult Inpatient/Observation	99252	99253	99254	99255

Discharge day care < 30 min	99238
Discharge day care > 30 min	99239

Critical care codes –Time based/Adult	99291		99292	
Critical care codes – day based/Pediatric	99471	99472	99475	99476
Critical care codes – day based/Neonatal	99468		99469	

Neonatal intensive care codes	99477	99478	99479	99480

Normal newborn care codes	99460	99461	99462	99463

4-SELECTION OF MDM-BASED E/M CODES

Because MDM based codes come in different levels, one may ask how the appropriate level is selected. This question is important because the higher the level, the more the reimbursement. MDM-based codes can be selected in 2 ways. The first one is MDM-based, and the second is time based. Each of these codes contains a specific level of MDM and a specific amount of time. The only thing you need to do then is to align your patients' MDM level or total time spent with the patient with the appropriate code that matches it.

Code Set	CPT code	Code level	Time	MDM level
Office New Patient	99202	Level 2	15 minutes	Straightforward
	99203	Level 3	30 minutes	low
	99204	Level 4	45 minutes	Moderate
	99205	Level 5	60 minutes	High
Office Established	99212	Level 2	10 minutes	Straightforward
	99213	Level 3	20 minutes	low
	99214	Level 4	30 minutes	Moderate
	99215	Level 5	40 minutes	High
Office Consult	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	low
	99244	Level 4	40 minutes	moderate
	99245	Level 5	55 minutes	High

Code Set	CPT code	Code Level	Time	MDM level
Hospital Admission	99221	Level 1	40 minutes	Straightforward/Low
	99222	Level 2	55 minutes	Moderate
	99223	Level3	**75 minutes**	High
Hospital Subsequent	99231	Level 1	25 minutes	Straightforward/Low
	99232	Level 2	35 minutes	Moderate
	99233	Level 3	**50 minutes**	High
Hospital Same day	99234	Level 1	45 minutes	Straightforward/Low
	99235	Level 2	70 minutes	Moderate
	99236	Level 3	**85 minutes**	High
Consult ER	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	Low
	99244	Level 4	40 minutes	Moderate
	99245	Level 5	**55 minutes**	High
Consult inpatient	99252	Level 2	35 minutes	Straightforward
	99253	Level 3	45 minutes	Low
	99254	Level 4	60 minutes	Moderate
	99255	Level 5	**80 minutes**	high

Example: for an established patient in the office, if the MDM level for that patient is low, then the appropriate code to choose for billing is 99213. This exemplifies MDM-based code selection. For another established patient in the office: If you provided 40 minutes of care, then you can select the highest level, 99215, irrespective of MDM. This exemplifies time-based code selection.

It is clear that an MDM-based code can be selected via 2 different pathways. The question then arises, which pathway should I choose? Is one pathway better than the other? Answer is "it depends"! Use the pathway that will get you the highest level. For example, if you saw an established patient in the office with a simple URI, then this kind of patient typically qualifies for straightforward MDM, so you can only bill level 2 (99212). Now imagine a situation where the mother asked you too many questions about viral illnesses and how to manage them, and you spent a lot of time educating the mother about childhood viral illnesses and how to prevent or manage them, and you ended up spending 40 minutes of total time. If this is the case, you should bill the highest level of 5 based on time, although, based on complexity or MDM, the patient only qualifies for level 2.

On the hospital side, a similar example may be subsequent day care for a bronchiolitis/reactive airway patient who is doing well and improving. This patient typically qualifies for low level MDM, hence level 1 (99231), but if you provide asthma education for 50 minutes, then you can select the highest code level of 99233.

On the other hand, if you admit a patient with severe asthma exacerbation, which typically qualifies for high MDM, then even if you have spent only 30 minutes with the patient, you can still select the highest level of code, 99223, based on the MDM pathway. In this example, if you base your code selection on time, you can only get the lowest level of 99221.

5-TOTAL TIME – DETAILED EXPLANATION

Prior to 2022/2023, you could only base code selection on time when the dominant part of the service was counseling and coordination of care. This is why old attestations universally stated "***more than 50% of my time spent in counseling and coordination of care***." Furthermore, only the time spent in the room, face-to-face with the patient, counted, not your 20-minute chart review before seeing the patient. It all changed in 2022/2023: now almost everything you do for patient care counts toward the total time, and you can base code selection on time at any time you like, regardless of counseling and coordination of care, so you no longer need the old attestation. You don't need to be on the patient's floor or office for the time to count.

1. Preparing to see the patient: **chart review, review of tests**.
2. Obtaining and/or reviewing separately obtained **history.**
3. Performing a medically appropriate **examination and/or evaluation.**
4. **Ordering** medications, tests, or procedures.
5. **Counseling** and educating the patient/family-caregiver.
6. **Referring and communicating** with other health care professionals.

7. **Coordination** of care.

8. **Documenting** clinical information in the electronic or other health record ~ **writing notes.**

9. Independently **interpreting results** and communicating results to the patient/family.

Do not count time spent on the following: Performance of other services that are reported separately with another CPT code. Example: providing procedural sedation and billing an E/M service code such as 99233 on the same day. Because procedural sedation is reported with another CPT code, time spent on procedural sedation is not counted toward the total time for the code 99233. Do not also count the time spent on teaching that is general and not limited to the discussion that is required for the management of a specific patient.

The definition of time for critical care differs slightly from that for the rest of the E/M service codes. To deliver critical care, you should be immediately available to the patient. The practical result of this requirement is that when you are off the patient's floor, you cannot deliver critical care. If you are a hospitalist, you can count 30 minutes spent in the radiology department looking at MRI results with a radiologist, but the same thing doesn't count toward critical care time because you are not immediately available to the patient unless radiology happens to be next door to the ICU or you look at the MRI with the radiologist in the ICU. Another difference is that daily updates or time spent with caregivers do not count toward critical care unless these discussions affect evaluation and management. Apart from these 2 exceptions, everything you do for a patient also counts toward critical care time, as long as you are immediately available to the patient.

6- MEDICAL DECISION MAKING (MDM) - DETAILED EXPLANATION

MDM is an objective way to describe or report how complex or sick a patient is. The sicker or more complex the patient, the higher the MDM. CPT describes 4 different levels of MDM. Each level has strict requirements. **Understanding and choosing among different levels of MDM is the most complex billing topic.** The following is the detailed description of what exactly each level of MDM means.

MDM has 3 elements shown in table below. For simplicity, we use short names: problems, data, and risk.

	ELEMENTS OF MDM
Problems	Number and Complexity of **Problems** Addressed at the Encounter
Data	Amount and/or Complexity of **Data** to Be Reviewed and Analyzed
Risk	**Risk** of Complications and/or Morbidity or Mortality of Patient Management

Based on the complexity of its elements, MDM has 4 different levels: straightforward, low, moderate, and high. Accordingly, each element also has 4 levels, as shown in the table below. For instance, high-level MDM includes high acuity problems, extensive data, and high risk.

An important thing to know is that only 2 of 3 elements are required to qualify for a given MDM level. It is also important to note that any combination of 2 elements is enough. You do not need all 3 lined up. If the data element does not qualify for a given MDM level, you can still get to that MDM level by using risk and problems. If the problem element does not reach a certain MDM level, you can still get

that level by using data and risk elements. If the risk element does not reach a certain MDM level, you can still get that MDM level by using problem and data element.

Elements of MDM			
	Problems	**Data**	**Risk**
Straightforward MDM	Minimal	Minimal to none	Minimal
Low level MDM	Limited	Limited	Low
Moderate level MDM	Moderate	Moderate	Moderate
High level MDM	High	Extensive	High

Definition or explanations of the terms and conditions that are used to describe each element was given in the tables below. A clear understanding of these terms/conditions is very important in selecting the appropriate level of MDM.

CONDITIONS LISTED UNDER PROBLEMS – CPT DEFINITIONS *(in italic)*
Self-limited or minor problem *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.* Examples: Simple URI, diaper rash, mosquito bite.
Stable, chronic illness *A problem with an expected duration of at least one year or until the death of the patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic.* Any chronic condition that is at target or goal management endpoints. Examples: well-controlled hypertension, diabetes, eczema, asthma. If the patient is not at the target or goal, it is classified as unstable, even if the status is long standing.
Acute, uncomplicated illness or injury *A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.* The distinction between a self-limited or minor problem and an acute, uncomplicated illness or injury is not always clear cut. Any self-limited or minor problem that is not resolving as expected or not responding to treatment automatically becomes an acute, uncomplicated illness or injury. For example, a common cold that has not resolved after a week, for which you suspect a bacterial superinfection, may be considered an acute, uncomplicated illness. Unlike the common cold, an uncomplicated influenza infection may be considered in this group as well. Other examples: cystitis, allergic rhinitis, sinusitis, simple ankle sprain.
Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care *A recent or new short-term problem with low risk of morbidity for which treatment is required.*

There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting. Example: UTI requiring hospital admission for IV antibiotic.
Stable, acute illness *A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.* Example: UTI improving but not resolved on antibiotic.
Chronic illness with exacerbation, progression, or side effects of treatment *A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.* Any chronic illness that is not in goal control range: poorly or not adequately controlled diabetes. Any chronic illness that is worsening or progressing: asthma exacerbation.
Undiagnosed new problem with uncertain prognosis *A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.* Example: a patient with pancytopenia of unclear etiology.
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.* Examples: pneumonia, pyelonephritis.
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. Examples: head injury with loss of consciousness
Chronic illness with severe exacerbation, progression, or side effects of treatment *The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.* Example: severe asthma or congestive heart failure exacerbation
Acute or chronic illness or injury that poses a threat to life or bodily function *An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.* Examples: severe anaphylaxis, septic shock

Having one subheading in the problem section is good enough to meet the requirement for that level.

Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient

management. As an example, a patient with hypertension, diabetes and hypothyroidism. Hypothyroidism does not count in MDM selection as long as it is not addressed or its presence affects the medical decision making. Take home message: The mere presence of multiple conditions does not automatically make a patient complex unless these problems are addressed or affect decision making.

ELEMENTS OF DATA – CPT DEFINITIONS *(in italic)*
Amount and/or Complexity of Data to Be Reviewed and Analyzed **Analyzed:** *The process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.* No double counting/dipping: If you order a CBC in an encounter and subsequently review the CBC result during the same encounter, this cannot be counted as two elements—one for ordering and one for reviewing. It must be counted as a single unit. You can't also count a test if you report it with a CPT code. If you run a urine analysis in your office, you cannot count either the order or the review of the UA, as you will request reimbursement for UA with a specific CPT code.
Minimal or none Minimal or no data. Self-explanatory, no explanations were given by CPT. Only used in straightforward MDM.
Ordering of each unique test ***Test:*** *Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test.* ***Unique****: A unique test is defined by the CPT code set. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes.*
Review of the result(s) of each unique test Order and review of a test considered as one unit. Typically, this element applies when you review a test result from a standing/recurring order outside the encounter, or when you review a test result ordered by other providers.
Review of prior external note(s) from each unique source ***External:*** *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

A unique source *is defined as a physician or other qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM*

Other than physician assistants and advanced nurse practitioners, there is no universally accepted list of who is included in the term 'qualified health care professional'. It is basically a trained and licensed healthcare worker who can report healthcare services independently of physicians, and also includes physical therapists, dietitians, clinical social workers, pharmacists, respiratory therapists, but not nurses. So, if you review a note from a nurse practitioner or dietitian that counts, but reviewing a note from a nurse does not count.

For example, for a pediatric hospitalist, any other specialty, such as surgery, ER, or another pediatric subspecialty, is an external source, even within the same hospital or department. Only notes considered internal would be those from the physicians within the same hospitalist group. So if you are a pediatric hospitalist and review the ER resident note, then that counts.

Assessment requiring an independent historian(s)

Independent historian(s): *An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.*

For pediatrics, we almost always use independent historians. So this element is almost always automatically checked.

Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)

Independent interpretation is described by CPT as "The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test."

If you look at a CXR yourself and document what you see, that counts; but if you copy paste a radiologist's note or never interpret the CXR yourself and rely only on the CXR report, that does not count. You should document this in your note as "My independent interpretation of CXR: ……..or I personally reviewed the EKG, which shows…."

Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported).

Discussion: *Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange.*

Appropriate source: *For the purpose of the discussion of management data element, an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregiver.*

Examples: Discussion of MRI findings on the phone with radiologist or pathology findings with pathologist. Management discussions with any other consulting services/physicians. Discharge planning discussions with a case manager.

Data element is the most regulated or demanding element of MDM.

RISK ELEMENT- CPT DEFINITION

*One element used in selecting the level of service is the **risk of complications and/or morbidity or mortality of patient management** at an encounter. This is distinct from the risk of the condition itself.*

***Risk:** The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. **Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions.** For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.*

Based on the above definition, the risk element is about the complications, morbidity, and mortality from our interventions (or lack of interventions), not necessarily the risk of the condition itself.

Unlike problem or data element, there is no quantification of risk element. It has no subheadings. Some conditions were listed only as an example. This is the least regulated element of MDM, and appropriate level selection is largely left to physicians, as described above.

Examples

■ ***Prescription drug management.***

Prescription drug management is based on documented evidence that the provider has evaluated the patient's medications as part of a service. Simply listing current medications is not considered prescription drug management. At its core, this element just requires documentation from the provider stating that the medication was evaluated for the patient's condition. This may involve discussions on efficiency, tolerance, side effects, etc.

• Starting, stopping, modifying, refilling, or deciding to continue a prescription medication and documenting your thought process are all included in prescription drug management. "*stable hypertension, continue valsartan 10 milligrams, will refill for 4 months until the next follow up visit." is enough documentation.* Just listing the medication is not enough. This risk even applies when a prescription medication is considered but not started yet, or not started based on patient preferences. Documentation of the thought process is all that is needed.

Although this risk category typically applies to prescribed medications, Over the counter medications may also be included. An example may be the use of NSAIDs in a patient with chronic kidney disease. NSAIDs may have significant side effects in this patient and may count toward the risk, as long as clear documentation is made in the chart about the rationale of usage or avoidance of these agents.

■ ***Diagnosis or treatment significantly limited by social determinants of health***
Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity. This is when patients' lack of finances, insurance, food, housing, etc., affects your ability to diagnose, manage, and care for them as you normally would.*

■ ***Drug therapy requiring intensive monitoring for toxicity.***
This term is self-explanatory. A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed to assess these adverse effects, not primarily to assess therapeutic efficacy. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. Example, monitoring CBC for cytopenia during chemotherapy. Another example would be vancomycin levels.

■ ***Decision regarding hospitalization or escalation of hospital-level care.***
Self-explanatory. Anytime you are admitting a patient from ER or sending a patient from floor to ICU.

■ ***Decision not to resuscitate or to deescalate care because of poor prognosis.***
Self-explanatory.

■ ***Parenteral controlled substances***
Self-explanatory. Include iv opioids, iv benzodiazepines or any other iv controlled substance.

Now that we are comfortable with terminology, let's take a detailed look at each MDM level.

Straightforward is the first and simplest level of MDM.

Straightforward MDM	**Problems**	Minimal • 1 self-limited or minor problem
	Data	Minimal or none
	Risk	Minimal risk of morbidity from additional diagnostic testing or treatment

Examples of straightforward MDM are a simple URI, mild diaper rash, or clean bug bite. All of these conditions involve **only one** self-limited or minor problem. There are typically no prior notes from an external source to review, no tests to order or review, and the risk is minimal. If you obtain the history from a parent, then data elements qualify for one higher level of low MDM, but you would still have 1/3 elements fulfilled for low level MDM, and hence cannot reach the low level MDM, as you need 2/3 elements.

	Office codes	Hospital Codes	Consultation codes	ER codes
E/M codes with Straightforward MDM	99202 99212	99221 99231 99234	99242 99252	99282

Next level of MDM is low.

Low MDM	**Problems**	**Low** *(must meet the requirement of only one of the subheading below)* ■ 2 or more self-limited or minor problems or ■ 1 stable, chronic illness or ■ 1 stable, acute illness or ■ 1 acute, uncomplicated illness or injury or ■ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care.
	Data	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)* **<u>Category 1: Tests and documents</u>** **Each unique test, order, or document contributes to the combination of 2* ■ 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 **<u>Category 2: Assessment requiring an independent historian(s)</u>**
	Risk	Low risk of morbidity from additional diagnostic testing or treatment

As shown in the table, there are 2 ways to meet the data element requirement at this level. The first pathway is meeting Category 1 requirements by reviewing test results or other providers' notes or ordering tests. Only 2 items are needed. Examples: looking at a CBC result and reading a note from an ER doctor. Looking at the CBC result and ordering BMP or CXR. The second pathway is meeting category 2 requirement by having an independent historian. In pediatrics, we almost always have an independent historian (parents/caregivers), so from the data element perspective, our patients at least qualify for low level MDM.

Examples of low-level MDM are simple UTI, sinusitis, AOM, influenza infection, ankle sprain.

	Office codes	Hospital Codes	Consultation codes	ER codes
E/M codes with low level MDM	99203 99213	99221 99231 99234	99243 99253	99283

Next level of MDM is moderate.

	Problems	**Moderate** *(must meet the requirement of only one of the subheading below)* ■ 2 or more stable, chronic illnesses, or ■ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment, or ■ 1 undiagnosed new problem with uncertain prognosis, or

		■ 1 acute illness with systemic symptoms, or ■ 1 acute, complicated injury
Moderate **MDM**	Data	**Moderate** (Must meet the requirements of at least 1 out of 3 categories) **<u>Category 1: Tests, documents, or independent historian(s)</u>** **Each unique test, order, or document contributes to the combination of 3* ■ 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 **<u>Category 2: Independent interpretation of tests</u>** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) or **<u>Category 3: Discussion of management or test interpretation</u>** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
	Risk	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

1st and 2nd data categories in the low level MDM data element merge together and become the 1st data category in moderate and high level of MDM. Moderate and high levels then add two more categories: (2nd) independent interpretation of tests and (3rd) discussion of management or test interpretation. Meeting the requirement of only one category is good enough. 3 items are needed for Category 1.

Examples of moderate level MDM: a patient with well controlled hypertension and DM. A patient with poorly controlled eczema or ADHD. Acute pneumonia or pyelonephritis. Asthma exacerbation.

	Office codes	Hospital Codes	Consultation codes	ER codes
E/M codes with moderate level MDM	99204 99214	99222 99232 99235	99244 99254	99284

Last and highest level of MDM is high.

High MDM	**Problems**	**High** *(must meet the requirement of only one of the subheading below)* ■ 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
	Data	**Extensive** (Must meet the requirements of at least 2 out of 3 categories) **<u>Category 1: Tests, documents or independent historian(s)</u>** **Each unique test, order, or document contributes to the combination of 3* ■ 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 **<u>Category 2: Independent interpretation of tests</u>** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) Or **<u>Category 3: Discussion of management or test interpretation</u>** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
	Risk	**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 or escalation of hospital-level care ■ Decision not to resuscitate or to deescalate care because of poor prognosis ■ Parenteral controlled substances

High level MDM data element has the same 3 categories as the previous moderate level MDM. In high level though 2/3 categories must be met not 1/3 as in the moderate level.

	Office codes	Hospital Codes	Consultation codes	ER codes
E/M codes with high level MDM	99205 99215	99223 99233 99236	99245 99255	99285

Examples of high level MDM: severe asthma or CHF exacerbation, severe traumatic brain injury, septic shock.

Let's assume that as a hospitalist, you are consulted on a patient with an acute severe asthma exacerbation in the ER. The table below shows how you can plug the elements together to reach the high-level MDM. You don't need to fulfill all 3 elements, as in this example, 2/3 is enough. If you evaluated the patient and decided that the patient needed to be admitted to the ICU but not to the floor. In this situation, even if you spent only 15 minutes of care on this patient, you can still select the highest level of consult code (99245 = 55 minutes) because this patient's MDM qualifies for high level. You do not need to, and preferably should not, document how much time (15 minutes) you spend with the patient, as the patient clearly has a high level MDM.

High level MDM	Problem	Acute severe asthma exacerbation = 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment	
	Data	Category 1	Review of CBC ordered by ER physician Ordering BMP Reading ER physician note Taking history from the mother
		Category 2	Independent interpretation of CXR
		Category 3	Discussing management with ER attending
	Risk	High risk = Decision regarding hospitalization or escalation of hospital-level care.	

MDM based code sets typically have 3 to 5 levels.

Typically, last digit of the code set indicates the level.

4 or 5 level code sets

MDM	-	Straightforward	Low	Medium	High
Code Level	Level **1**	Level **2**	Level **3**	Level **4**	Level **5**
Office –New Patient	Code deleted	9920**2**	9920**3**	9920**4**	9920**5**
Office - established	9921**1**	9921**2**	9921**3**	9921**4**	9921**5**
Consult outpatient	Code deleted	9924**2**	9924**3**	9924**4**	9924**5**
Consult inpatient	Code deleted	9925**2**	9925**3**	9925**4**	9925**5**
ER	9928**1**	9928**2**	9928**3**	9928**4**	9928**5**

Level of MDM and level of code set may be quite confusing, as seen above, because the first code level is either nonexistent or a non MDM based code. The first MDM level of straightforward correlates with the second level in the above code sets. Codes 99201, 99241, and 99251 were deleted in recent years. You may be tempted to think that 99242 is the level 1, but it is still considered level 2 because of historical usage.

3 level code sets.

MDM level	Straightforward or low	Medium	High
Code Level	Level **1**	Level **2**	Level **3**
Admission	9922**1**	9922**2**	9922**3**
Subsequent	9923**1**	9923**2**	9923**3**
Same day	99234	99235	99236

7- PRACTICAL TIPS ON CODE SELECTION

Tips on office and consultation code selection

Level 1 (~99211) is easy to decide as it is for a visit that does not require physician attention. Like a weight check by a nurse. The remaining 4 codes can be selected based on either time or MDM. If the code selection is based on time, it is still a very clear and straightforward process. Just match the total time you spend with the patient to the appropriate code. Difficulty and confusion may arise when MDM is used for code selection, because you cannot open a cheat sheet and plug in MDM elements each time you see a patient. Below are some tips to make MDM based code selection easier.

Focus on the patient's problem first when selecting the MDM level. This fulfills the first MDM element; you then need only one more: data or risk.

Simple problems, like a common cold or a diaper rash, are easy to code because they only qualify for level 2 (~99212). This level is not very difficult to decide. Typically, these patients have very simple, self-resolving illnesses; there is minimal to no data to review, and the risk from management is minimal. From the documentation perspective, there is not much to document other than the simple problem and your recommendations.

Most complex problems, such as severe asthma exacerbation or septic shock, qualify for level 5 (~99215). These patients are typically very sick, carry a high risk of morbidity and mortality, and require review of multiple data elements.

The rest of the problems are in between, either level 3 (~ 99213) or level 4 (~99214). Separating level 3 from level 4 becomes the most difficult task.

Although one self-limited problem qualifies for level 2, if you address 2 self-limited problems, it universally qualifies for level 3 in pediatrics because of the independent historian of data element. For example, if you see a child with a common cold, you can only report level 2; but if the same patient has diaper rash and you address it during the same visit, you can then bill level 3. Take home point is that you should always look for additional simple problems to address to bring level 2 to level 3 in pediatrics.

Because we almost always have an independent historian who fulfills the low-level MDM data element that aligns with level 3, any of the following conditions automatically qualify for level 3: any stable/well-controlled chronic illness, such as well-controlled hypertension, or any acute, uncomplicated illness, such as a UTI. From the documentation perspective, it’s important to document that history is obtained from the caregiver.

Level 4 (~99214) codes require moderate MDM, which has a detailed data element. So it may be easier to get to level 4 using the problem and risk element. Anytime you prescribe a medication (prescription drug management) then risk element of the moderate MDM is fulfilled then you only need a qualifying condition and not worry about data. 2 stable/well controlled chronic condition, any one chronic condition that is not well controlled or with progression or exacerbation, one acute illness with systemic symptoms like pneumonia or undiagnosed new problem with uncertain prognosis. All of these problems qualify for moderate MDM, and if you happen to write a prescription, then you have 2/3 elements fulfilled and can easily report level 4 code.

Example, *"8 years old with ADHD on 10mg amphetamine. Caregivers report frequent issues at school and home. Physical exam and vitals, including blood pressure, were within normal limits. ADHD is not well controlled with 10 mg, and we will increase amphetamine to 20mg and reevaluate in 3 months".* This very short note is perfectly enough to report the level 4 code of 99214. It has a medically appropriate history and examination, and moderate level MDM, including a chronic problem that is not well controlled, and moderate risk given prescription drug management. You do not need any data as 2/3 elements are fulfilled.

In 2022, Medicare had 98 million paid claims for 99214 and 76 million paid claims for 99213. From the above example, it's easy to see why level 4 overtakes level 3 because it is not very difficult to get it. Anytime you see any chronic condition that is not in the target goal range and prescribe/continue a medication, then it's a level 4 claim.

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Anytime you order a CXR and prescribe an antibiotic, level 4 can be selected because you can document your independent interpretation of CXR, which takes care of the data element, prescription takes care of the risk element, and you do not need to worry about the problem element; 2/3 fulfilled.

Another way to reach level 4 is to use "diagnosis or treatment significantly limited by social determinants of health under risk element" instead of a prescription when social factors limit your ability to diagnose or treat a patient's condition.

Typically, level 5 is reached through problems like severe exacerbation of a chronic condition or a life threatening illness, but if you evaluate patient for hospital admission (Decision regarding hospitalization under high risk element) then you can still report level 5 if you have enough data elements like independent interpretation of a test, management discussions with another physician or review of labs, notes.

Tips on inpatient code selection

Inpatient code sets have 3 levels. There is not much to worry about the level 1 codes (~99231. This is the default level when patient complexity does not reach the moderate or high level of MDM.

Hospital level 2 codes (~99232) have moderate level MDM. You can reach the moderate level MDM as described above in the office section, primarily using the problem element. Two well controlled chronic illnesses or any chronic condition that is not well controlled or an acute illness with systemic symptoms or an undiagnosed new problem with unclear prognosis, plus medication prescription or socially limiting factors.

Any chronic condition that needs to be managed in the hospital is not well controlled by definition, and hence, a patient like this qualifies for at least level 2 because we will most certainly use some medications for that condition. This applies even if the patient is responding well to treatments and otherwise well. You just need to document it appropriately.

Example: *"6-year-old patient admitted with asthma exacerbation. No retractions this morning; end expiratory wheezing present; vitals within normal limits. Asthma exacerbation improving, given improvement in clinical status, we will wean albuterol to q4hr.* This note clearly qualifies for level 2. Note that both a chronic condition with exacerbation and medication management were documented.

Compared with the office, we order more labs, have plenty of external notes to review from different providers, and have more discussions with other physicians. Given this difference, using data elements is more common on the inpatient side. We almost always prescribe some medications in the hospital, so it may be easier to get to level 2 by using data and risk elements and not worry about the problem. Any prescription medication plus only one of the following: independent interpretation of a test (like CXR or EKG), management discussions with another physician, or a combination review of a lab, review of an external note, and history from a caregiver will get you level 2. Prescription can be swapped with limiting social factors.

Examples: a patient was admitted with concern for aspiration pneumonia. You documented your independent review of CXR and prescribed antibiotics. A patient was admitted with GER. You discussed management with the GI specialist and started or adjusted the PPI dose. A patient on IV antibiotics for soft tissue infection, and you had a combination of review of CBC, procalcitonin order, and history from the mother. All these patients qualify for hospital level 2.

Hospital/inpatient level 3 involves high level MDM. You can get to high level MDM primarily by using the problem element as described above. Any chronic illness with severe exacerbation or any life-threatening illness, plus enough data element. When a patient is this sick, there is typically an excess of labs to review and other physicians or providers to consult. Unlike moderate MDM, you need to fulfill 2 data categories.

Examples: a patient admitted with severe asthma exacerbation, plus independent interpretation of CXR and management discussion with a pulmonologist. A patient admitted with severe IBD exacerbation, plus a combination of CBC review, review of GI note, and history from caregiver and management discussions with GI. A patient with severe bronchiolitis, plus an independent review of CXR, and a combination of CBC review, review of an ER physician's note, and history from the caregiver.

Another way of getting hospital level 3 is by using risk factors listed under high risk. These include: drug therapy requiring intensive monitoring for toxicity, decision regarding hospitalization or escalation of hospital-level care, decision not to resuscitate or to deescalate care because of poor prognosis, and use of parenteral controlled substances. If you have one of these risk factors, then you only need to add appropriate data or problem element.

Examples of drug therapy requiring intensive monitoring for toxicity: checking daily electrolytes while on IV fluids to prevent electrolyte imbalances. Checking vancomycin levels to prevent toxicity. Checking daily creatinine while on Zosyn or Toradol to prevent AKI. *Example: a patient with hyponatremia on IV fluids, q12-hour BMP checks to prevent IV fluid toxicity, plus review of BMP, ER note, caregiver history,*

and independent interpretation of EKG. This patient's problem may not be severe enough for high level MDM, but you can still reach high level MDM using risk and data elements.

Decision regarding hospitalization or escalation of hospital-level care, plus enough data element. *Example: you saw a patient with bronchiolitis in the ER and decided to admit, plus an independent review of CXR and management discussion with the ER physician. You saw the same patient the next day on the floor and decided to transfer the patient to the ICU, plus independent interpretation of the new CXR and management discussions with intensivist.*

Decision not to resuscitate or to de-escalate care because of poor prognosis, plus enough data element. Example: *You saw a patient with terminal CF and placed a DNR order, plus independent interpretation of CXR and management discussion with pulmonologist.*

Parenteral controlled substances. *Example: a patient with acute pancreatitis and severe abdominal pain requiring IV morphine plus independent review of KUB and management discussions with GI.*

Data and risk elements may be very helpful in practical code selection for inpatient and ER consultation codes, because there will typically be plenty of labs, imaging, and notes to review, and consideration of hospital admission, escalation of care, or IV opioid therapy.

CHAPTER 4 - E/M SERVICE CODE SETS

OFFICE/OUTPATIENT CODES

New Patient	-	99202	99203	99204	99205
Established Patient	99211	99212	99213	99214	99215

All these codes are for sick visits, not for well child checks. 99211 is a non-MDM-based code for simple follow-ups, such as BP or weight checks. These can be done by a nurse and do not require a physician's time. When 99211 is excluded, both new and established patient codes have four levels that correspond to the four MDM levels: straightforward, low, medium, and high. These codes are used by all types of physicians practicing in the office, regardless of specialty. These codes are also visit based, so one code from this set is reported for each visit. If you see an unlucky child first at 9 am for URI and then again at 3 pm for an acute arm fracture, you should report 2 different codes: the first for the 9 am visit and the second for the 3 pm visit. Each visit gets one code. Modifier 25 needs to be added to the second reported CPT code to show it is a separate service.

Inpatient admission codes

Initial hospital inpatient or observation care	99221	99222	99223

This code set has 3 levels, all of which are MDM-based. These codes are used to report admissions to both inpatient and observation settings. Used only once per admission. Not used if admission and discharge is on the same date. Given that it is day-based code, the codes from this group are reported only once per day. This is why you do not need to write a separate note (from the billing perspective) if a patient is admitted after midnight and you are rounding in the morning. In this situation, you cannot report the admission codes which is already been reported, and you cannot report the subsequent day care code because it is not yet a subsequent day.

Subsequent day care

Subsequent hospital inpatient or observation care	99231	99232	99233

This code set has 3 levels, all of which are MDM-based. These codes are used to report subsequent care/follow-up on days other than the admission day and discharge day. Not used if admission and discharge is on the same date. Given that it is day-based code, the codes from this group are reported only once per day.

Same day admission and discharge care codes

Same day	99234	99235	99236

This code set has 3 levels, all of which are MDM-based. These codes are reported when both admission and discharge happen on the same date. These codes have nothing to do with 24 hours but only with the date. If a patient is admitted at 9pm and discharged at 11pm on the same day/date, then one code

from this set is used to report the 2 hours of admission. If the same patient is admitted at 11pm and discharged at 1am the next day, then the first code (99221-99223) is used for the admission at 11pm, and the second code (99238 or 99239) is used for the discharge at 1am the next day. Given that it is a day-based code set, the codes from this group are reported only once per day.

Discharge day care codes

99238	*Hospital discharge day management, 30 minutes or less*
99239	*Hospital discharge day management, more than 30 minutes*

Both are non-MDM-based codes. These codes are used to report all care provided on discharge day. These codes include, as appropriate, final examination, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, preparation of discharge records, prescriptions, and referrals. These codes are reported only once per day. These codes are to be utilized to report all the E/M services provided to a patient on the date of discharge.

CONSULTATION CODES

Outpatient	99242	99243	99244	99245
Inpatient	99252	99253	99254	99255

This code set has 4 levels and is all MDM-based, which aligns with MDM levels. ER is considered to be an outpatient setting. If you see a consult in the ER, use outpatient consultation codes for patients who are not admitted. If you are consulted and the patient is admitted to the hospital by another service, use inpatient consultation codes even if you saw the patient in the ER.

Consult codes are used only once for a specific referral question; subsequent codes are then used to follow up on the patient. In the office setting, use appropriate follow-up codes (99212-99215) for follow-up visits. In hospital settings, use appropriate subsequent-day care codes (99231-99233). In the hospital setting, the consult code is used only once during the entire hospitalization.

The consultant physician should consider selecting different ICD codes from the primary attending when reporting services. This clarifies that their care was distinct from that provided by the primary attending. If the same ICD codes are used, the payer may reject the consultant's services as duplicates.

The request and the reason for consultation should be documented in either the requester's note, the consultant's note, or in a written order. Consultation codes should not be used when a physician is called to transfer care, but may be used if the decision to accept patient care cannot be made without first evaluating the patient.

EMERGENCY DEPARTMENT SERVICE CODES

ER codes	99281	99282	99283	99284	99285

99281 is a non-MDM code for minor problems that do not require a physician's attention or time. The remaining 4 codes are all MDM-based and align with 4 MDM levels.

Although typically used by ER providers, this code set is not restricted to ER physicians; any physician who serves as the primary physician in the ED can use these codes. This applies to physicians who have ER privileges and see their patients in the ER without any involvement of ER doctors. Non-ER physicians are typically consulted on ER patients and use appropriate admission, consultation, or critical care codes.

For critically ill patients, critical care codes 99291 and 99292 can be used by any physician to report critical care services. If pediatric or neonatal critical care codes are used at admission, then critical care in the ED is not reported separately by the same admitting provider/group. If a pediatric/neonatal patient received critical care services in the ED but was not admitted under the provider, and care was transferred to another physician/group or another facility, then critical care codes 99291 and 99292 should be used regardless of the age. The same provider cannot report both critical care and ED codes for the same patient on the same date.

CRITICAL CARE SERVICES ~ Time based

99291	*Critical care, evaluation and management of the critically ill or injured patient, 1st 30-74 minutes*
99292	*each additional 30 minutes.*

These codes, also known as adult critical care codes, are time-based. Although the code descriptor doesn't specify any requirements, the CPT code book allocates several pages on how and when these codes are used. The definition of terms used in critical care billing by CPT is given below.

A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability *of imminent or life-threatening deterioration in the patient's condition.*

Critical care involves high complexity medical decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

As long as the patient's condition meets the CPT definition of critical care, these codes can be used. By definition, critical care involves high-level MDM, so all critical care codes are MDM-based. Because all critical care codes have the same MDM level, MDM does not affect code selection; therefore, I group them with non-MDM-based codes for code selection purposes. By definition, there should be an acute vital organ impairment with a high probability of deterioration. If there is no acute vital organ impairment or high risk of deterioration, then there is no critical illness from the CPT perspective, and these codes cannot be used. Example: a 10-year-old in the PICU for q1 hour neurochecks for acute traumatic epidural bleed with a perfectly normal neurological examination. Can you bill critical care for this patient? Given that there is no acute impairment in the neurological system, it is hard to argue for

critical illness from CPT perspective. This patient perfectly meets the definition of critical illness when he develops an altered mental state, because then he would have an acute impairment of a vital organ, the brain.

This code set includes a bundle containing 19 procedural CPT codes that cannot be reported separately. Any procedure not included in the bundle, such as intubation or central line placement, can be reported separately.

These codes are not reserved for intensivists and can be reported by any physician. They can be considered universal critical care codes and are used in the following situations, **regardless of age**.

1-In the outpatient setting (office, ER).

2- By consulting physicians (consulting physicians cannot use neonatal/pediatric critical care codes).

3-By physicians physically transporting critically ill patients over the age of 2 years.

4- When a patient younger than 6 years of age is transferred to another physician group in a separate institution (*or another physician group in the same institution).* For the day of the transfer, the transferring physician uses time-based critical care codes, and the accepting physician uses initial neonatal/pediatric critical care codes.

5- Patients aged 6 years (72 months) and above.

Age-dependent selection is the most common use of these codes, but the first 4 situations are good examples of their universal application. Neonatal/Pediatric critical care codes are only reserved for admission under inpatient status, and are only reported once a day, as they are per-day codes and only reported by primary/admitting physicians. Once reported, neonatal/pediatric critical care encompasses all critical care provided that day, including critical care in the ED by the same provider/group.

Critical care (99291, 99292) and other E/M services may be provided to the same patient on the same date by the same individual. For example, 99233 can be reported in the morning, and if the patient worsens and requires intubation later, 99291 can be reported by the same physician in the afternoon.

As a rule, critical care (99291, 99292) requires undivided attention, and a physician can provide critical care to only one patient at a time, meaning an intensivist can report a maximum of 24 hours of critical care time in a calendar day. Another rule concerns 2 physicians providing critical care (99291, 99292) to a critically ill patient simultaneously. In this situation, only one physician can report critical care at a time. A patient can receive a maximum of 24 hours of critical care services in a day.

Because critical care codes 99291, 99292 are time-based, the total time of critical care should be documented in the patient's chart/note. Critical care of less than 30 minutes is reported with other appropriate E/M service codes, like subsequent hospital codes.

99291 is actually the 1st hour of critical care (it was defined that way prior to 2000). New description: 30-74 minutes is still consistent with 1 hour because nothing less than 30 minutes is critical care, and to report the first block of 30 minutes with 99292, the midpoint of 30 minutes should be reached. The midpoint of 30 minutes is 15 minutes, and when 15 minutes is added to 60 minutes, 75 minutes is reached. Because the first 14 minutes of the additional 30 minutes may not be separately reportable, 99291 includes services up to 74 minutes. Clock for the first unit of 99292 starts ticking at 61 minutes

and reaches a reportable level at 75 minutes. For the second unit of 99292, the clock starts ticking at 91 minutes and reaches a reportable level at 105 minutes. When these considerations are combined, the first hour of critical care is practically 30-74 minutes. Although some intensivists document *"I provided 30-74 minutes of critical care……"* in their note, it is better to document instead *"I provided 1 hour of critical care…..".* There are several reasons not to use this range of minutes. There is a big difference between 30 and 74 minutes, and it indicates a clinician who doesn't have a good sense of how much time is spent on patient care. Time for 99292 only starts after 60 minutes and is reported when it reaches 75 minutes. If you document 30-74 minutes, then it is not clear when the time for 99292 starts, and reporting 99292 becomes problematic.

The complexity of our healthcare industry's billing practices is best exemplified by Medicare's different rules for reporting 99292. Although CPT allows 99292 to be billed at 75 minutes as explained above, Medicare mandates that the clock starts ticking at 74 minutes and 99292 is reported when its full 30 minutes are spent, which practically means that the first 99292 block can be reported only at 105 minutes (74+30).

CRITICAL CARE SERVICES-NEONATAL/PEDIATRIC: ~ Day based

Neonatal	99468	*Initial inpatient neonatal critical care, per day, for the evaluation and management of critically ill neonate, 28 days of age or younger*
	99469	*Subsequent inpatient neonatal critical care, per day, for the evaluation and management of critically ill neonate, 28 days of age or younger*

Pediatric	99471	*Initial inpatient pediatric critical care, per day, for the evaluation and management of critically ill infant or young child, 29 days through 24 months of age*
	99472	*Subsequent inpatient pediatric critical care, per day, for the evaluation and management of critically ill infant or young child, 29 days through 24 months of age*
	99475	*Initial inpatient pediatric critical care, per day, for the evaluation and management of critically ill infant or young child, 2 through 5 years of age*
	99476	*Subsequent inpatient pediatric critical care, per day, for the evaluation and management of critically ill infant or young child, 2 through 5 years of age*

Similar to time-based critical care codes, there are no specific requirements beyond the requirement for critical illness. The same definition of critical care applies to adults, children, and neonates. As it's clear in the description, these codes are based on day rather than time. Similar to time-based critical care codes, these code sets are also based on MDM because critical care involves high level of MDM.

These codes may be reported only by a single physician/primary attending and only once per day/date, per patient. Use of these code sets is not limited to pediatric and neonatal intensivists and can be used by other ICU physicians. Initial care codes (99468, 99471, 99475) may only be reported once per hospital admission. If a patient is readmitted to the ICU during the same hospitalization, then subsequent codes are used. Consultants may report 99291 or 99292 for critical care services, while the primary attending reports neonatal/pediatric critical care codes.

These codes are not used

1-In the outpatient setting (office/clinic, ED), regardless of age. Only reserved for inpatient use.
2-By consultants. Use is restricted to the primary/admitting attending group.
3-For transport or critically ill patients of any age.
4- When a patient is transferred to another physician group in a separate institution (*or another physician group in the same institution).* For the day of the transfer, the transferring physician uses time-based critical care codes, and the accepting physician uses initial-day-based critical care codes.
5- Patients aged 6 years (72 months) and above.

The popular name given to these codes, bundled codes, is a misnomer, as time-based critical care codes also have a bundle. The bundle of neonatal/pediatric critical care codes contains 39 procedures, 20 more than the time-based critical care codes. Procedures in the bundle are not reported separately, and any procedure that is not in the bundle is reported separately. Intubation is in the bundle of this code set and is not reported separately.
When a neonate or infant becomes critically ill and require critical care services who already received care (hospital services, neonatal intensive care services or normal newborn services) and transferred to another provider then first provider either report time based critical care (99291-99292), hospital based services (99221-233), neonatal intensive care (99477-99480) or normal newborn services (99460-99463) but only one of these groups. Accepting provider reports neonatal/pediatric critical care codes.
When a neonate, infant, or child becomes critically ill on the same day they have received normal newborn care, hospital care, intensive care, and the same individual assumes critical care to report neonatal/pediatric critical care codes, then only normal newborn care is reported separately. Hospital care services, intensive care services, and care in the ED are included in the pediatric/neonatal critical care codes.

PEDIATRIC CRITICAL CARE TRANSPORT SERVICES

There is a special code set for pediatric critical care transport for patients less than 2 years of age. Codes 99466 and 99467 are used when the physician actually attends the transport and physically manages the transfer of the critically ill child. Codes 99485 and 99486 are used when a physician supervises a transport team on the phone. The same physician can't report both code groups simultaneously. If a transport is already physically carried out by a physician, then another physician cannot report supervising codes of 99485/99486. Pediatric critical care transport codes 99466 and 99467 include a bundle very similar to the time-based bundle.

99466	*Critical care face to face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger;* ***first 30-74 minutes of hands on care during transport***
994477	***; each additional 30 minutes***

99485	*Supervision by a control physician of interfacility transport care of critically ill or critically injured pediatric patient, 24 months of age or younger, includes 2-way communication with transport team before transport, at the referring facility, and during the transport, including data interpretation and report****; first 30 minutes***
99486	***; each additional 30 minutes***

Face-to-face critical care transport services provided by physicians to patients aged 2 years or older can be reported using time-based critical care codes 99291 and 99292. There are no specific E/M codes for the transfer of non-critically ill patients, but code 99082 can be reported. 99082: Unusual travel (eg, transportation and escort of patient).

NEONATAL INTENSIVE CARE SERVICES-IN PATIENT

Initial	99477	*Initial hospital care, per day, for the evaluation and management of the neonate, 28 days or younger, who requires intensive observation, frequent interventions and other intensive care services.*
Subsequent	99478	*Subsequent intensive care, per day, for the evaluation and management of the recovering VLBW infant (present body weight less than 1500 grams)*
	99479	*Subsequent intensive care, per day, for the evaluation and management of the recovering LBW infant (present body weight of 1500-2500 grams)*
	99480	*Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)*

Intensive care is defined as ***services for infants or neonates who are not critically ill but continue to require intensive cardiac and respiratory monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring, and constant observation by the health care team under direct supervision of the physician***. These codes are based on day rather than time.

This code set is not MDM based. There are no specific documentation requirements beyond ensuring that the provided services meet the CPT definition of intensive care. Intensive care is defined as services for infants or neonates who are not critically ill but continue to require

1- Intensive cardiac and respiratory monitoring.

2- Heat maintenance support.

3- Enteral and/or parenteral nutritional adjustments.

4- Laboratory and oxygen monitoring.

5- Constant observation by the health care team under the direct supervision of a physician.

Note for 99477 should include the patient's age, as this code applies only to infants 28 days or younger. Note for 99478, 99479, and 99480 should document the infant's current daily weight, as these codes are weight-based codes.

These codes may also be used for infants in the PICU instead of 99231-99233 if the infant requires and meets the definition of intensive care services.

The initial intensive care code 99477 may only be reported for neonates (less than 28 days old), regardless of weight. Subsequent neonatal intensive care codes 99478, 99479, and 99480 can be reported for any infant (up to 12 months) as long as the patient weighs less than 5kg. If an infant is older than 28 days or more than 5 kg, then none of these intensive care codes may be reported. For example, a 1-day-old 32 weeks 32-week-old premature baby (birth weight 2 kg) was admitted to the NICU. The

baby was not critically ill but required intensive care. First day 99477 is reported. Baby stayed in the NICU for 6 months for feeding issues and continued to require intensive care. For the remainder of the stay, subsequent neonatal intensive care codes were used until the patient reached 5 kg, at which point subsequent hospital care codes (99231-99233) were used to report daily E/M services. Another example is a 1-day-old baby who is 5.2 kg (infant of diabetic mother), who was admitted to NICU and required neonatal intensive care services. For this baby, 99476 may be reported for the first day, but even if the baby continued to require intensive care, subsequent-day intensive care codes may not be used because the baby is more than 5kg.

Neonatal intensive care codes also include a bundle, which contains the same 39 CPT codes as neonatal/pediatric critical care codes.

Code 99477 can be reported once per hospitalization and is not reported if an initial neonatal critical care code has already been reported. If an initial neonatal critical care code is already reported and the patient improves and does not meet the definition of critical care but still requires intensive care, then subsequent neonatal intensive care codes are used.

NORMAL NEWBORN CARE SERVICES

99460	*Initial hospital or birthing center care, per day, for E/M of normal newborn infant*
99461	*Initial care, per day, for E/M of normal newborn infant seen in other than hospital or birthing center*
99462	*Subsequent hospital care, per day, for E/M of normal newborn infant*
99463	*Initial hospital or birthing center care, per day, for E/M of normal newborn infant admitted and discharged on the same date*

Use of normal newborn codes is limited to initial care of the normal newborn in the first days of life after delivery. E/M services for the normal newborn include maternal, fetal, and birth history; physical examination(s); ordering diagnostic tests and treatments; meeting with family; and documentation in the medical record. This code set is neither MDM nor time-based. These are day-based codes and reported once per date/day. In the hospital setting, 99460 is reported on the first day and 99462 on subsequent days. 99463 is for admission and discharge on the same date.

These codes are not used if the newborn is anything other than normal. Use appropriate E/M codes for not-normal babies, including hospital, intensive, and critical care codes. The same physician or members of the same group cannot bill a newborn care service with a hospital admission code on the same day. For example, a newborn was seen in the morning, and 99460 was billed. Baby got sick and was admitted to the floor in the afternoon for IV antibiotics. Although a different physician group may use the hospital admission code 99223, the same physician may not bill both the normal newborn code and the hospital admission code on the same day; either should bill the normal newborn code or the hospital admission code for that day.

DELIVERY ROOM ASTTANDANCE AND RESUSCITATION SERVICES

99464	*Attendance to delivery (when requested by physician) and **initial stabilization of newborn***
99465	*Delivery room **resuscitation, provision of positive pressure ventilation and/or chest compressions** in the presence of acute inadequate ventilation and/or cardiac output.*

99464 is reported only when the provider's presence is requested by a delivering physician or other qualified health care worker, indicating a high-risk patient. 99464 includes initial drying, stimulation, suctioning, blow-by oxygen and CPAP administration. These codes are not included in normal newborn care and are reported separately. Procedures that are done in the delivery room, like these 2 codes and other procedures like intubation and central line placement, can be reported separately in addition to the neonatal critical/intensive care codes by the same provider as long as these procedures are performed as part of resuscitative efforts and not as a convenience prior to admission. Code 99465 includes the same services as code 99464, so these 2 codes are not reported together. CPAP administration is covered under 99464, but if the patient requires positive-pressure ventilation, 99465 is reported.

STAND BY SERVICES

99360	*Standby service, requiring prolonged attendance, each 30 minutes, (standby for cesarean/high risk delivery, operative standby, stand for frozen section)*

This code can be used by physicians/pediatricians attending deliveries. This service should be requested by another physician. This code is reported with normal newborn examination (99460) or neonatal resuscitation (99465), but not with initial neonatal stabilization (99464). If the time is less than 30 minutes, 99360 is not reported.

PROLONGED SERVICES

There are 2 different types of prolonged service code sets for physicians. The first is for prolonged services on the same day/date as the encounter, and the second is for prolonged services on any day/date other than the encounter day.

1-Prolonged service with or without direct patient contact on the date of an E/M service

Outpatient	99417	*Prolonged outpatient E/M service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time.*
Inpatient	99418	*Prolonged inpatient or observation E/M service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time*

Basically, these codes exist so you can request additional revenue when you spend too much time with a patient on the day/date of the encounter (the day you physically saw the patient). These codes support the concept that almost everything you do for the patient counts toward the total time, and when in excess, you can bill for that extra time, irrespective of the setting in which it is spent.

As is clear from the above definitions, this code set originates from an existing E/M service and is reported only when the time associated with that E/M service code is exceeded by more than 15 minutes. For example, the level 5 office code of 99215 has a time requirement of 40 minutes when the

total time is used for code selection. What happens if you spend 55 minutes? Then you can report 99215 plus 1 unit of 99417 (40 + 15 = 55). If you spend 70 minutes, then you can report 99215 plus 2 units of 99217 (40+15+15).

You cannot report these codes without reporting a relevant E/M service code first for the same date. 99217 is typically used with one of the following: 99205, 99215, 99245. 99418 is typically used with one of the following: 99223, 99233, 99236, 99255.

To report these codes, the related E/M service code should have an upper time limit, such as 50 minutes for 99233, so that the clock starts ticking for prolonged care when this upper limit is passed and reported when it reaches 15 minutes. If there is no upper limit time, the clock cannot start ticking. Because of this, these codes cannot be used with any E/M service codes that have no upper time limit, such as normal newborn codes, ER codes, critical care codes, intensive care codes, well-child check codes, or hospital discharge day care codes.

Another requirement is that the initial E/M service code selection should be based on time, and the highest level in the code set should be reported. So you cannot use 99417 with 99214. You need to report the highest-level code, like 99215, in the code set first. You can't use 99418 with 99232; you should report the highest-level code, like 99233, first. You also cannot use 99417 or 99418 if the initial code selection is based on MDM. Example: you billed 99215 or 99233 based on MDM, which means you did not document how much time you spent with the patient. In this situation, you cannot report 99417 or 99418 because there is no initial time to start from for each additional 15 minutes.

Each code represents an additional 15 minutes. Any duration less than 15 minutes is not reported. Clock starts ticking when the time in the initial E/M service is exceeded, but not reported until a full 15 extra minutes is reached. So, if you spend 64 minutes on the floor, you cannot report 99418 because 99233 has 50 50-minute requirement and 50+14=64 (you need a full 15 minutes). For the same patient, if you spend 79 minutes, then you can only report 1 unit of 99418 (50+15+14).

With direct patient contact means that prolonged service was provided face-to-face while in the patient's room. Example: spending too much time taking a history and performing a physical examination, and counseling while in the patient's room.

Without direct patient contact means that prolonged service is provided without direct face-to-face patient contact (not in the patient's room), such as reviving labs or imaging, talking with a consultant on the phone, or coordination of care, all carried out while not in the patient's room. Examples: in the office, you saw a patient at 9 am, the patient left at 10 am, and you discussed this patient's management with a consultant on the phone at 5pm. Similar example in the hospital: after seeing a patient on the floor, you went to the radiologist's room, spent an hour reviewing the MRI images, and discussed the findings.

Lastly, these codes can only be reported on the day of the original E/M service. If you saw the patient on Monday, then you cannot use these codes for an hour-long discussion with a consultant on Tuesday.

2-Prolonged service without direct patient contact on the date other than the face to face E/M service

99358	*Prolonged evaluation and management service before and/or after direct patient care; first hour*
99359	*Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes*

These codes exist so you can request additional revenue for time spent for a patient on any day you have not seen the patient face-to-face. Example: if you see a patient on Monday morning, you can report the prolonged services for a prolonged conversation with a consultant you had on Monday night using 99417 or 99418, but what if the consultant doesn't answer and calls you back the next day and has an hour-long discussion? What now? You can't use 99417 or 99418, it's not the same day anymore. This is exactly the situation to use this code set.

To use these codes, there must be an E/M service of reference, either in the past or in the future. Example: reviewing a NICU discharge, 3 months' worth of files on Monday, and seeing the actual patient on Wednesday. You probably need a separate note, or at least an addendum, to your reference E/M service note regarding this prolonged service. Documenting what you did and the total extra time.

The big difference between this code set and 99417/99418 is that you can use these codes (99358, 99359) with any other E/M service codes, and the referenced E/M service does not need to be time-based. Remember, you could not use 99417 with 99214 because you need to go to the highest level in the code set first, but you can use 99358 with 99214 or any relevant code in the code set, and it doesn't matter whether 99214 is time or MDM-based.

99358 is used for the first hour of prolonged service and is not reported if the prolonged service is less than 30 minutes. 99359 is an add-on code and is reported only after 99358. 99359 is used to report each additional 30 minutes and is not reported if additional time is less than 15 minutes. Example: you saw a patient on Monday, reported 99213, and then spent 130 minutes on Tuesday reviewing the chart and talking with multiple consultants. Then appropriate billing would be 99213 for Monday and 99358 plus 2 units of 99359 (60+30+30+10 =130, the last 10 minutes do not qualify for an additional unit of 99359).

This code set is typically for outpatient physicians, because it would be unusual for an inpatient physician not to see their patient on the day they are providing care. This code set can be reported by inpatient physicians when they are on call and do not physically see the patient face-to-face. For example, a hospitalist on call at home gets a call from a resident at night, discusses patient management for 40 minutes, and sees the patient the next day. The hospitalist can report 99358 for the night discussion and the relevant E/M service the next day. In a rare situation, let's say you were the hospitalist on Monday and were off service Tuesday, but were somehow called about a patient you took care of on Monday and spent 1 hour coordinating care; then you can bill 99359. Consultants may also use these codes when they discuss the patient care, but do not see the patient on the same day of initial discussion, but see the patient on another day.

Prolonged staff services: *99415-99416.* This is yet another prolonged service codes for nursing staff in the outpatient clinic. Physicians can use these codes to report prolonged services delivered by nurses under their supervision in the office.

PREVENTIVE MEDICINE SERVICES

This code set is used in the outpatient setting and is commonly referred to as well-child checks. These codes are only for preventive medicine/well-child checks, including sports participation examinations. If any significant problem is identified and addressed during the encounter, it should be reported with appropriate E/M service codes using modifier 25. Modifier 25 lets the payer know that management of the problem was a separate service from the well-child check. An insignificant or trivial problem identified during a well check is included in the well check and not separately reported. If you see a patient for a well-child check and address his acute sinusitis, then you should bill both the preventative medicine service code and the appropriate E/M service code.

New Patient	99381	***Initial comprehensive preventative medicine*** *evaluation of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory diagnostic procedures, new patient;* ***infant (age younger than 1 year)***
	99382	***; Early childhood (age 1 through 4 years)***
	99383	***; Late childhood (age 5 through 11 years)***
	99384	***; Adolescent (Age 12 through 18 years***
Established Patient	99391	*Periodic comprehensive preventative medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory diagnostic procedures, established patient;* ***infant (age younger than 1 year)***
	99392	***; Early childhood (age 1 through 4 years)***
	99393	***; Late childhood (age 5 through 11 years)***
	99394	***; Adolescent (Age 12 through 18 years***

Separately reportable services, such as immunizations, office labs, and screening tests (e.g., vision and hearing), are not included in preventive care services and should be reported separately.

Preventive medicine, individual counseling, new or established patients

Preventive medicine counseling and risk-factor reduction interventions will vary with age and should address issues such as family problems, diet and exercise, substance use, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter.

99401	*Preventative medicine counseling, and or risk factor reduction intervention(s) provided to an individual (separate procedure);* ***approximately 15 minutes***
99402	*;* ***approximately 30 minutes***

There are also several other preventive medicine CPT codes that are used for individual counseling (99401, 99402, 99403, 99404), behavior change interventions (99406, 99407, 99408, 99409), group counseling (99411, 99412).

Medical Team Conference ~ Team Meeting (Case Management Service)

The medical team conference requires face-to-face participation of a minimum of 3 qualified health care professionals from different specialties or disciplines. There are 2 different types. The first type of medical team conference involves direct face-to-face contact with the patient and/or the patient's caregiver or guardian. The second type is a medical team conference with only providers and no direct contact with the patient or caregiver. The distinction is important because how you bill the time you spend in the team meeting depends on whether the patient/caregiver is in the meeting. If the patient or caregiver giver present in the meeting, then the physician will report the time using appropriate E/M service codes, including prolonged service. If the patient/caregiver is not present at the meeting, physicians will report time using 99367.

Medical team conference, direct (face to face) contact with patient and/or caregiver.
Physicians: use appropriate E/M service codes including prolonged service codes

Medical team conference without direct (face to face) contact with patient and/or family
Physicians: use code 99367. Less than 30 minutes is not reported separately.

99367	*Medical team conference, with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more, participation by physician*

TELEMEDICINE CODES

Telemedicine services are synchronous, real-time, and interactive encounters between a provider and a patient. There are 2 types of telemedicine services. The first one is a combined audio-video, and the second one is audio-only. Telemedicine services are not used to report routine communications related to a previous encounter, such as discussing lab results with the patient. They are intended for evaluation and management services, similar to in-person office codes. Telemedicine services may be used for follow-up of previous face-to-face E/M services, such as evaluation of treatment response or complications from therapy initiated at the previous visit. Telemedicine services are not reported on the same day/date of another E/M service. If they are done on the same day, then MDM elements and time are summed up and reported as an aggregate so that they are counted only once. When telemedicine and in-person services are provided on the same day, the time for telemedicine services can still be counted toward the total time of the in-person service, regardless of how long the telemedicine service lasted.

In 2025, AMA added 17 new telemedicine codes, 98000-98016. These are the only E/M codes that do not start with 99 thousand. Except for 98016, the rest (16 codes) are MDM-based codes that can also be based on time. The wording and usage of these 16 codes are very similar to those of in-person office visit codes.

98016 is a non-MDM-based code and differs significantly from the rest of the telemedicine codes. It is simply used for triaging patients. It is an audio-only telemedicine service that involves 5 to 10-minute-long medical discussions. It is only for established patients. This service is patient-initiated and intended to determine whether a more extensive visit type is required, such as a face-to-face office visit. It can be considered as patient triage through an audio connection. It should not originate from an E/M service

within the prior 7 days and should not lead to a new visit within the next 24 hours or the soonest available.

The 16 telemedicine codes can be divided into 2 groups.

1) Synchronous audio-video evaluation and management services: 4 codes for new patients and 4 codes for established patients. No minimum time is required to report these codes.

2) Synchronous audio-only evaluation and management services: 4 codes for new patients and 4 codes for established patients. A minimum time of 10 minutes is required for these codes, even if the code selection is based on MDM.

4 code subgroups follow the 4 levels of MDM and are worded very similarly to office codes.

These codes are all reported once per day. Do not report these codes with same-day in-person E/M service. Prolonged service care codes can be used with these codes.

Tables below show the new and established patients' telemedicine codes and how they relate to office codes. It is clear that the codes in the same column are identical in terms of MDM level and total time. For example, codes 99205, 98003, and 98007 all have high MDM and 60 minutes of total time. The only minor difference is that audio-only codes have a minimum 10-minute time requirement.

MDM		Straightforward	Low	Moderate	High
Time		15 minutes	30 minutes	45 minutes	60 minutes
New Patient	Office – in person	99202	99203	99204	99205
	Audio-Video	98000	98001	98002	98003
	Audio only	98004	98005	98006	98007

MDM		Straightforward	Low	Moderate	High
Time		10 minutes	20 minutes	30 minutes	40 minutes
Established Patient	Office – in person	99212	99213	99214	99215
	Audio-Video	98008	98009	98010	98011
	Audio only	98012	98013	98014	98015

The use of this new code set is another example of the complexity of our billing regulations. Just because a CPT code exists does not mean it is accepted by payers. This code set was introduced in 2025, and CMS has not yet accepted these codes. Instead, CMS asks the providers to report regular office codes with modifier 93 for audio-only visits and modifier 95 for audio-visual visits. Given that these codes align perfectly with office codes, there would be no significant difference.

ONLINE DIGITAL E/M SERVICES

Codes 99421, 99422, 99423 involve patient-initiated services. The patient reaches the physician online via an app, email, etc., about a problem, and the physician addresses it using evaluation and management. If the encounter or interaction does not include evaluation and management, these codes may not be reported, such as when discussing a lab result on the internet app. The patient should be an established patient, though the problem can be new. These services require permanent storage of online encounters. These service codes cover the total care minutes over 7 days (one week). 99421: 5-

10minutes. 99422: 11-20 minutes and 99423: 21 minutes or more of total care time, in one week from the time of initial contact. These codes cannot be used if the patient is seen within 7 days before or after the initial online contact. This code set is not a universally reimbursed service, nor is it covered by MediCal. Further information can be found in the CPT book E/M section.

Interprofessional telephone/internet/electronic health record consultation

The 99446, 99447, 99448, and 99449 codes are used by consulting doctors to report their time for both verbal opinion and written report. Code 99451 is used when only a written report is given. Code 99452 is for the referring doctor. There are many rules about when and how this code set can be used. Only 9999451 and 99452 are covered by MediCal. Consultants can't use these codes if they saw the patient in the last 14 days or will see the patient in the next 14 days. 99452 can't be used separately by the physicians who are requesting the consult if they have seen the patient on the same day. Further information can be found in the CPT book E/M section.

Digitally stored data services/Remote physiologic monitoring.

These codes are used to report services when a physician monitors various physiologic parameters online, transmitted from the patient's device to the physician. Parameters monitored include weight, blood pressure, pulse oximetry, respiratory rate, and ECG. This code set includes 99453, 99454, 99091, 99473, 99474, 99457, and 99458, and is used by only a few physicians/specialties. Further information can be found in the CPT book E/M section.

ADVANCE CARE PLANNING

These codes are time-based and used to report face-to-face service between a physician or other QHCP and a patient, family member, or surrogate in counseling and discussing advance directives with or without completing relevant legal forms. These codes are not used with critical care codes but can be used with other E/M codes.

99-497: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms when performed) by the physician; first 30 minutes, face to face time with the patient, family members and/or surrogate

+99498: each additional 30 minutes

CHAPTER 5 – NON-E/M CPT CODES

Although all physicians need to know some E/M service codes in detail, the number and which non-E/M codes they need to know depend on their specialty and subspecialty. Given that there are thousands of non-E/M codes to cover and that each specialty/subspecialty uses its own CPT codes, this chapter will provide only a superficial discussion of common non-E/M CPT codes used by different pediatricians. I strongly recommend that physicians take their time and scroll through the pages of a CPT code book and the AAP billing for pediatrics book to see which non-E/M CPT codes can be reported in their practice. You will be surprised by how many CPT codes you didn't know about that can be used to increase RVU generation. We will divide this chapter into the practice settings and subspecialties.

Please note that only a few sample codes are listed below without code descriptors or much explanation, just to demonstrate other potential code groups. One needs to read more about these codes before using them. A short list of frequently used non-E/M service codes was provided in tables at the end of the chapter.

OFFICE/OUTPATIENT PRACTICE

Depending on individual physicians' comfort levels, pediatricians can perform and report many surgical procedures in the office. These procedures include incision and drainage, removal of skin tags including congenital accessory digits, wedge excision of skin of nail fold for ingrown toe nail, laceration repairs, suture removal, simple burn care, destruction of benign lesions/warts, chemical cauterization of granulation tissue, foreign body removal from skin/eye/ear/nose, controlling nose bleed, venipuncture or blood sampling for diagnostic study, replacement of gastrostomy tube, urinary catheterization, labial adhesion lysis, newborn circumcision and removal of impacted cerumen.

Office physicians can also report the professional component of radiological studies, such as CXRs, if there is no radiologist read. Laboratory tests performed in the office, such as urine analysis and rapid strep/influenza/RSV, also needed to be reported with CPT codes.

The most important medicine codes that pediatricians need to know are vaccine administration codes. There are 6 different codes for vaccine administration. The first group applies specifically to pediatric patients and involves physician counseling on the benefits and side effects of each vaccine component. So if you discuss a pentavalent vaccine with family, you have provided 5 different counseling on 5 different infectious agents.

90460: *immunization administration through 18 years of age via any route of administration, with counseling by physician; first or only component of* ***each vaccine*** *or toxoid* is used for each vaccination injection

90461: each additional vaccine or toxoid component.

These 2 codes can only be used when the patient is under 18 years old and counseling is provided. If the patient is older than 18 years or if the physician did not provide counseling, then these codes cannot be reported.

Example: a 15-month-old patient receives physician counseling and DTap-IPV/Hib, PCV13, and influenza vaccines. 3 units of 90460 are reported for each vaccine as stated in the code. The physician counseled on 7 different infectious agents, and a total of 7 agents were administered. 3 of the

counseling/administration are covered in 3 units of 90460; the remaining 4 are reported with 4 units of 90461.

The remainder of vaccine administration codes are for patients over the age of 18 or patients of any age who didn't receive counseling on vaccines from a physician.

90471: Immunization administration (includes PC, ID, SQ or IM); 1 vaccine (single or combination)

90472: each additional (single or combination) vaccine administered

90473: Immunization administration by intranasal or oral route; 1 vaccine (single or combination)

90474: ; each additional vaccine (single or combination)

90471/90472 is used for parenteral vaccines. 90473/90474 is used for nasal or oral vaccines. A big difference between 90460 and 90471/90473 is that the 90460 group covers all components of the vaccine, whereas the 90471/90473 group only covers each shot or administration, but not the components. Because of this, reimbursement is more with the 90460 group (99460-99461).

Example: a 15-month-old patient receives no physician counseling (nurse visit for vaccines) and receives DTap-IPV/Hib, PCV13, and influenza vaccines. 1 unit of 90471 is reported for the first vaccine, and 2 units of 90472 are reported for the remaining 2 vaccines.

Each vaccine has a unique CPT code. This unique vaccine code must also be reported with the administration codes. CPT code for PCV 13 is 90670.

Other medicine CPT codes that office physicians can use include immunoglobulins like tetanus Ig and its administration codes, hearing and vision screen, EKG, inhaler/nebulization treatments, pulse oximetry, and IV infusion. Hearing and vision screening codes can be reported with well-child check visits.

There are codes that can be used when care is delivered to a patient when the office is not supposed to be open or when care is delivered on an emergency basis. When these codes are used, reimbursement may be higher. There are 3 codes that may bring higher RVU in this category.

99050: Services provided in the office at times other than regularly scheduled office hours, when office is normally closed (holidays, Saturday, Sunday), in addition to the basic service.

99051: services provided in the office during regularly scheduled evening, weekend or holiday office hours, in addition to the basic service.

99058: Services provided on an emergency basis in the office, disrupting other scheduled services, in addition to the basic service

INPATIENT PRACTICE

Many of the surgical procedures listed under outpatient may also be performed by hospitalists, but in a hospital setting, these procedures are most often performed by consulting physicians. IO insertion, venipuncture requiring physician skills, bladder aspiration with needle, foley insertion, LP, bone marrow aspiration, and moderate sedation are among the few procedures pediatric hospitalists may perform

and report with appropriate CPT codes. If a hospitalist uses propofol for procedural sedation, then anesthesia codes should be reported.

SUBDIVISIONS

Pediatric and neonatal intensivist may report the same procedural codes used by outpatient and hospitalist but on top of that they may need to report codes for intubation, CPR, cardioversion, placement of various central lines including PICC and umbilical lines, placement of arterial line, IO insertion, anesthesia codes when deep sedation is used, moderate sedation, g-tube or tracheostomy change, tracheostomy, bronchoscopy, thoracentesis, pericardiocentesis, chest tube placement, ECMO codes, exchange transfusion, LP, initiation of hypothermia. Intensivists may use radiology codes for procedures that require imaging guidance, such as ultrasound-guided vascular access or needle placement.

Pulmonologists may use codes from the respiratory section of surgery (30, 31, 32 thousand series), like codes for various forms of bronchoscopy, and the respiratory section of medicine (94 thousand series), like codes for pulmonary function tests, inhaler/nebulizer administration, or evaluation/teaching.

Cardiologists may use codes from the cardiovascular section of surgery (33 to 37 thousand series), like codes for pericardiocentesis, insertion of transvenous pacemaker, and under the cardiovascular section of medicine (92, 93 thousand series), like codes for EKG, ECHO, ASD closure, various cardiac catheterizations, and stent placement.

Gastroenterologists may use codes from the digestive section of surgery (40 thousand series), such as codes for upper/lower endoscopies and liver biopsy, as well as codes from the gastroenterology section under medicine (91 thousand series), such as codes for GI motility studies and acid reflux tests.

Endocrinologists may use codes from the endocrine section of medicine (95 thousand series), like codes for ambulatory continuous glucose monitoring.

Neurologists may use codes from the neurology section of surgery (61 to 64 thousand series), like code for LP, and may use codes from the neurology section of medicine (95 thousand series), like codes for sleep study, EEG, and nerve conduction studies.

Hematologists/Oncologists may use codes from the hematology section of surgery (38 thousand series), like codes for bone marrow transplantation and chemotherapy administration codes under medicine (96 thousand series.

Nephrologists may use codes from the urinary section of surgery (50 to 53 thousand series), like codes for renal biopsy, Foley insertion, and may use codes from the dialysis section of medicine (90 thousand series), like codes for various dialysis care services.

Adolescent medicine may use IUD insertion code under female reproductive system/surgery and behavioral evaluation codes under medicine.

Rheumatologists may use codes from the musculoskeletal section of surgery (20 thousand series), like codes for various joint injections, and may use codes from medicine, like codes for various immune globulin and biologic drug administrations.

Allergist/Immunologist may use codes from the allergy section of medicine (95 thousand series), like codes for various allergy testing and immunotherapy.

Geneticists may use codes from the genetic section of medicine (96 thousand series), like codes for various genetic counseling services.

There are probably not many specific procedures for **Infectious Disease** physician because all cultures and lab work are reported by the hospital/pathologist.

Emergency Medicine specialists care for a very broad patient population and a wide range of pathologies. Given this ER physicians may use most of the codes listed for other subspecialties and more.

Developmental/Behavioral specialists may use codes from the behavioral section of medicine (96 thousand series), like codes for behavioral screen and evaluation.

Child psychiatry specialists may use codes from the psychiatry section of medicine (90 thousand series), like codes for various psychiatric services.

Obviously, the above list for each subspecialty is a significant underestimate, given concern for space and the fact that it was written by a pediatric intensivist. It's quite likely that plenty more potential codes would be identified when each subspecialist scrolls through the pages of the CPT code book. At least the above list gives each subspecialist a clue about where to look for the codes that may relate to their practice.

Further explanations of each non-E/M service CPT code group and a short list of procedures commonly used by pediatric providers are given below. CPT codes are written with a – sign between the numbers to make them easier to read **(not in the original CPT code).** CPT codes look less confusing with the – sign placed after the first two digits.

Anesthesia CPT codes

Any CPT code that starts with 0 is an anesthesia code. These codes are not reserved for anesthesiologists and must be used by pediatric intensivists or hospitalists when providing deep sedation for the procedures listed below.

ANESTHESIA CPT CODES	
Head/Neck	
00-104	Anesthesia for electroconvulsive therapy
00-124	Anesthesia for otoscopy
00-148	Anesthesia for ophthalmoscopy
Thorax/Intrathoracic	
00-410	Anesthesia for…… electrical conversion of arrythmias
00-520	Anesthesia for closed chest procedures (including bronchoscopy)
00-524	Anesthesia for pneumocentesis (thoracentesis)
00-532	Anesthesia for access to central venous circulation
00-540	Anesthesia for thoracotomy procedures …. - - - > *(for chest tube insertion!)*
00-560	Anesthesia for procedures on the heart, pericardial sac …. - -> *(for pericardiocentesis!)*

Spine	
00-635	Anesthesia for diagnostic/therapeutic LP
Abdomen	
00-702	Anesthesia for percutaneous liver biopsy
00-731	Anesthesia for upper GI endoscopic procedures
00-732	Anesthesia for ERCP
00-811	Anesthesia for lower intestinal endoscopic procedures
00-813	Anesthesia for combined upper/lower intestinal endoscopy
00-840	Anesthesia for intraperitoneal procedures in lower abdomen, NOS
Pelvis	
01-112	Anesthesia for bone marrow aspiration and or biopsy
Upper leg	
01-220	Anesthesia for all closed procedures involving upper 2/3 femur
Knee/popliteal	
01-420	Anesthesia for all cast applications, knee
Lower leg	
01-490	Anesthesia for lower leg cast application
Shoulder/Axilla	
01-680	Anesthesia for shoulder cast application
Upper arm/elbow	
01-730	Anesthesia for all closed procedures on humerus and elbow
Fore arm, wrist, hand	
01-860	Anesthesia for forearm, wrist, hand cast application removal…..
Radiological procedures	
01-922	Anesthesia for noninvasive imaging or radiation therapy
Burn	
01-951	Anesthesia for 2nd and 3rd degree burn excision, <4% BSA

Surgical CPT codes

CPT codes starting with 1 to 6 (10 thousand to 60 thousand series) are surgical codes. Non-surgical physicians, including pediatricians, use many of these surgical codes. A unique feature of surgical CPT codes is the surgical package. A surgical package simply means that other services are bundled within the procedure. The surgical package is also known as the global surgical period or postoperative period.

Surgical package contains:

1. E/M services subsequent to the decision to surgery on the day before and/or on the day of surgery (including history and examination).
2. Local or topical anesthesia.
3. Immediate post-operative care, writing orders, evaluation of patient in the recovery area.
4. Typical postoperative follow-up care.

Per CPT, complications, exacerbations, recurrences, and other unrelated diseases or pathologies are not included in the surgical package. The surgical package for a diagnostic procedure, such as an endoscopy, ends when the patient recovers from the procedure. Per CMS, all post-operative care, including complications related to the procedure itself, is included in the surgical package and not billed separately, except for complications requiring a return to the OR.

Apart from diagnostic procedures, CPT does not specify the duration of the surgical package. CMS has defined 3 surgical packages, or global surgical periods, that set the standard for the entire healthcare industry. These periods are 0, 10, and 90 days of the surgical package or post-operative periods. Procedures with O and 10 days of post-operative periods are called minor procedures, and procedures with a 90-day post-operative period are called major procedures.

CMS rules for additional related E/M services are given in the table below. Unrelated E/M services are never in the surgical period and may be reported separately with the modifier of 24.

Global Period	**0 day**	**10 days**	**90days**
Related E/M services before the date of procedure	Not included	Not included	All related service 1 day before surgery if after decision for surgery
Related E/M services on the date of procedure	E/M services typically included	E/M services typically included	All related service except E/M service at which decision for surgery is made
Related Postoperative E/M services	Same day (day 0 only)	All related care for 10 days	All related care for 90 days

Based on the above table, any related E/M service you provide on the day of a minor procedure is bundled in the procedure and not reported separately unless it is significantly beyond the pre-service time of that procedure. For major surgeries, surgeons can use the modifier 57 (decision to surgery) to indicate that E/M service was separate and beyond the pre-service time of the surgery.

Pediatricians rarely perform major procedures, so only 0 and 10 days of the surgical package are relevant for our practice and will affect how we report these codes. For example, you saw a 1-year-old with fussiness, obtained a complete history, performed a full system examination, and, to your surprise, found an ear foreign body, which you removed, and the fussiness resolved. How do you code for your services? Do you bill both for the office code (99212) and the procedure code (69200)? In this example, because you did not know the problem initially and performed an E/M service to find it, both the E/M service code and the procedure code can be reported together. Modifier 25 is added to 99212 to indicate that this EM service was separate from the procedure.

What if the patient is 10 years old and comes to you with a complaint of ear pain? You obtain a limited history and perform only an ear examination, find a foreign body, and remove it. How do you code for this encounter? In this case, the E/M service you provided, which is limited history and exam, is considered within the preservice of ear foreign body removal, and it makes sense. You should report only the procedure or the office code, not both at the same time. You can determine whether the office code or the procedure code has a higher RVU and report only the code with the higher RVU.

Another example, you saw a patient with ADHD and adjusted medications. The patient also complained about ear pain, and you identified and removed a foreign body. In this case, because ADH is unrelated to foreign body removal, both services should be reported simultaneously. (99214 with modifier 25 and 69200). Foreign body removal from the ear, or impacted cerumen removal, has a 0-day post-operative period and covers only the day of the procedure.

You reduced a nursemaid's elbow, which has a 10-day post-operative period, and the child came back 5 days later with an ear infection. In this situation, you should add modifier 24 to your office code, like 99213, to show that this E/M service was unrelated to nursemaid's elbow reduction.

SURGICAL CPT CODES	
Skin/Integumentary	
10-030	Image guided fluid collection drainage (eg, abscess, hematoma, cyst) soft tissue, percutaneous
10-060	I&D of abscess, simple or single (nonspecific location)
10-061	I&D of abscess, complicated or multiple
10-120	Incision and removal of foreign body, subcutaneous tissue; simple
10-121	Incision and removal of foreign body, subcutaneous tissue; complicated
11-100	Biopsy of skin SQ tissue, mucus membrane
10-120	Incision and removal of foreign body, SQ tissues, simple
10-160	Puncture aspiration of abscess, hematoma, bulla or cyst
11-200	Removal of skin tags (up to 15 by with scissor, ligature strangulation, electrocautery, chemical) *(removal of 6th digit)*
11-765	Wedge excision of skin of nail fold (for ingrown toe nail)
12-001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and or extremities (including hand and feet); 2.5cm or less
12-011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
15-853	Removal of sutures or staples not requiring anesthesia
15-854	Removal of sutures and staples not requiring anesthesia
16-000	Initial treatment of 1st degree burn, when no more than local treatment is needed
16-020	Dressing and/or debridement of partial thickness burns, initial or subsequent; small <5%TBSA
16-025	Medium, 5-10% TBSA
17-110	Destruction (eg, cryosurgery, electrosurgery, chemosurgery, surgical curettement) of benign lesions other than skin tags (*eg warts);* up to 14 lesions
17-111	; 15or more lesions
17-250	Chemical cauterization of granulation tissue
Musculoskeletal	
20-610	Arthrocentesis, aspiration and/or injection major joint or bursa (shoulder, hip, knee) without imaging guidance
20-950	Monitoring of interstitial pressure (includes insertion of device) in detection of compartment syndrome
23-500	Closed treatment of clavicular fracture; without manipulation

24-640	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation
26-010	Drainage of finger abscess, simple
26-011	Drainage of finger abscess; complicated (eg, felon)
29-125	Application of short arm splint
Respiratory	
30-100	Biopsy intranasal
30-300	Removal foreign body, intranasal, office type procedure
30-310	Removal foreign body, requiring general anesthesia
30-901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
30-903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method
31-231	Nasal endoscopy, unilateral or bilateral
31-500	Intubation, endotracheal, emergency procedure
31-502	Tracheostomy tube change, prior to establishment of fistula tract
31-505	Laryngoscopy, indirect, diagnostic
31-515	Laryngoscopy direct, for aspiration
31-603	Tracheostomy, emergency procedure, trans tracheal
31-605	Tracheostomy, emergency procedure; cricothyroid membrane
31-612	Tracheal puncture, percutaneous with transtracheal aspiration and/or injection
31-622	Bronchoscopy, rigid or flexible
31-624	Bronchoscopy, rigid or flexible, with BAL
31-635	Bronchoscopy, rigid or flexible , with removal of foreign body
32-551	Tube thoracostomy, open *(Chest tube insertion, surgical)*
32-554	Thoracentesis, needle or catheter aspiration of pleural space; without imaging guidance
32-555	Thoracentesis, needle or catheter aspiration of pleural space; with imaging guidance
32-556	Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance *(Pigtail insertion)*
32-557	;with imaging guidance *(Pigtail insertion)*
Cardiovascular/Heme	
33-016	Pericardiocentesis including imaging guidance, when performed
33-210	Insertion of temporary transvenous single chamber pacemaker catheter
33-211	Insertion of temporary transvenous dual chamber pacemaker catheter
33-619	Norwood procedure
33-946	VV ECMO initiation (1st day)
33-947	VA ECMO initiation (1st day)
33-948	VV ECMO, daily management each day (subsequent)
33-949	VA ECMO, daily management each day (subsequent)
36-000	Introduction of needle or intracatheter, vein
36-400	Venipuncture, younger than 3 years, necessitating skill of physician, not to be used for routine venipuncture; femoral or jugular vein
36-405	; scalp vein
36-406	; other vein

36-410	Venipuncture, age 3 years or older, necessitating skill of physician, for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36-415	Collection of venous blood by venipuncture
36-416	Collection of capillary blood specimen
36-420	Venipuncture, cutdown, ,<1year
36-425	Venipuncture, cutdown, ,>1year
36-430	Transfusion, blood or blood components *(report only if required to be infused by physician)*
36-440	Push transfusion, blood, 2 years and younger *(report only if required to be pushed by physician)*
36-450	Exchange transfusion, blood; newborn
36-455	Exchange transfusion, blood; other than newborn
36-456	Partial exchange transfusion, blood, plasma or crystalloid necessitating skill of a physician or other QHCP, newborn
36-510	Umbilical vein catheterization
36-511	Therapeutic apheresis; for WBC
36-512	Therapeutic apheresis; for RBC
36-513	Therapeutic apheresis; for Platelets
36-514	Therapeutic apheresis; for plasmapheresis
36-555	Insertion of non-tunneled centrally inserted CVC; < age 5years
36-556	; age 5years or older
36-557	Insertion of tunneled centrally inserted CVC without sq port/pump; < age 5yrs
36-558	; age 5years or older
36-568	Insertion of PICC without subcutaneous port/pump, without imaging guidance; <age 5 yr
36-569	; age 5years or older
36-572	Insertion of PICC without subcutaneous port/pump, with imaging guidance; <age 5 years
36-573	; age 5years or older
36-580	Replacement, complete, of a non-tunneled centrally inserted CVC, through same venous access
36-584	Replacement, complete, PICC, through same venous access
36-589	Removal of tunneled CVC, without subcutaneous pump/port
36-592	Collection of blood specimen using established central or peripheral catheter, venous
36-593	Declotting by thrombolytic agent of implanted vascular access device or catheter
36-600	Arterial puncture, withdrawal of blood for diagnosis
36-620	Arterial catheterization or cannulation for sampling, monitoring, percutaneous
36-660	Umbilical artery catheterization, newborn
36-680	Placement of needle for intraosseous infusion
37-191	Insertion of vena cava filter
38-220	Diagnostic bone marrow; aspiration(s)
38-221	Diagnostic bone marrow, biopsy(ies)
38-222	Diagnostic bone marrow, biopsy(ies) and aspiration(s)
Digestive system	
41-010	Incision of lingual frenum (frenotomy)

42-820	Tonsillectomy and adenoidectomy, <age 12 years
43-200	Esophagoscopy, flexible, trans oral, diagnostic
43-205	With band ligation of esophageal varices
43-227	With control of bleeding, any method
43-235	EGD, flexible, trans oral, diagnostic,
43-260	ERCP, diagnostic
43-752	Naso/Oro gastric tube placement requiring physician's skill and fluoroscopic guidance (includes, fluoroscopy, image documentation and report)
43-753	Gastric intubation and aspiration of therapeutic, necessitating skill of physician, (eg, GI hemorrhage) including lavage if performed
43-754	Gastric intubation and aspiration, diagnostic, single specimen (acid analysis)
43-761	Repositioning of NG/OG feeding tube, through duodenum for enteric nutrition
43-762	Replacement of G-tube, percutaneous, without imaging or endoscopy guidance
44-360	Small intestinal endoscopy
44-950	Appendectomy
45-378	Colonoscopy, flexible, diagnostic
47-000	Liver biopsy, needle, percutaneous
49-082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance
49-083	; with imaging guidance
49-084	Peritoneal lavage (including imaging guidance when performed)
49-418	Insertion of tunneled intraperitoneal catheter
49-440	Insertion of gastrostomy tube, percutaneous, under fluoroscopy
Urinary/Genital	
50-200	Renal biopsy, percutaneous
50-590	Lithotripsy, extracorporeal shockwave
51-100	Aspiration of bladder, by needle
51-600	Injection procedure for cystography or voiding urethrocystography
51-701	Insertion of non-indwelling bladder catheter (straight catheterization)
51-702	Insertion of temporary indwelling bladder catheter; simple (foley)
51-798	Measurement of post voiding bladder capacity by ultrasound, non imaging
54-150	Circumcision, using clamp or other device
54-450	Foreskin manipulation including lysis of preputial adhesions and stretching *(with clamp,* application of manual pressure do not count)*)*
56-441	Lysis of labial adhesions (use of an instrument, application of manual pressure do not count)
58-300	Insertion of IUD
Nervous, Eye/ENT	
62-270	Spinal puncture, lumbar, diagnostic
62-272	Spinal puncture, lumbar, therapeutic for drainage of CSF
62-273	Injection, epidural, of blood or clot patch
65-205	Removal of foreign body, external eye; conjunctival superficial
65-220	Removal of foreign body, external eye; corneal without slit lamp
69-090	Ear piercing
69-200	Removal foreign body from external auditory canal; without general anesthesia
69-209	Removal of impacted cerumen using irrigation/lavage, unilateral
69-210	Removal of impacted cerumen requiring instrumentation, unilateral

Radiology CPT codes

Radiology codes start with 7 (70 thousand series). Radiology codes always have 2 components. The first one is called the technical component, and it is about the expenditure of having appropriate machines and personnel to get the images. The second one is called the professional component and involves physicians reading the imaging and putting a note in the chart. If the office has an X-ray machine and CXR is done in the office, then the CPT code for CXR (71046) can be reported without any modifier. If a CXR is performed in another office and there is no radiology report, the physician, after reading the CXR and entering a read of the CXR in the patient's chart, can report 71046 with modifier 26 to indicate that only the professional part of the radiological procedure was performed. There are many more radiology codes that office physicians can report if these images are not read by a radiologist. If a radiologist has already read these images, then other physicians cannot report additional radiology codes. If an office physician reports a radiology code, these radiological tests cannot be used toward the MDM data element. Radiology codes are rarely reported by hospital-based physicians because, most of the time, the radiologist bills the professional component of the study, and the hospital reports the technical component.

RADIOLOGY	
74-018	Radiologic examination, abdomen; 1 view
71-045	Radiologic examination, chest; 1 view
76-937	Ultrasound guidance for vascular access *(add on code to primary procedure)*
76-942	Ultrasound guidance for needle placement (biopsy, aspiration, injection)
77-001	Fluoroscopic guidance for central vascular access, (*add on code to primary procedure)*
77-002	Fluoroscopic guidance for needle placement (biopsy, aspiration, injection) (*add on code to primary procedure)*

Laboratory/Pathology CPT codes

Laboratory/pathology codes start with 8 (80 thousand series). If a test is performed in the office, it should be reported with a lab CPT code. If blood was obtained in the office and sent to an outside lab, only the phlebotomy CPT code, not the lab CPT code, needs to be reported. In a hospital setting, labs are reported by the hospital (pathologist/biochemist), so hospital physicians never report lab codes.

PATHOLOGY AND LABORATORY	
81-000	Urine analysis with dipstick; with microscopy, non-automated
81-001	Urine analysis with dipstick; with microscopy, automated
81-002	Urine analysis with dipstick; without microscopy, non-automated
81-003	Urine analysis with dipstick; without microscopy, automated
81-025	Urine pregnancy test, by visual
82-247	Total bilirubin
82-272	Blood, occult, fecal

82-962	Glucose, blood by glucose monitoring device
83-655	Lead
85-013	Spun microhematocrit
88-720	Total bilirubin, transcutaneous
86-308	Heterophile antibodies (Monospot)
86-580	Skin test; tuberculosis, intradermal (PPD)
87-804	Influenza
87-807	RSV
87-880	Streptococcus, group A

Medicine CPT codes

Medicine codes start with 9 (90 thousand series). These codes are typically used by internists, but also include some invasive procedures like Swan-Ganz catheter placement and cardiac angiography codes.

	MEDICINE
Immunoglobulins	Many different products/codes. *Reported with administration codes 96365-96375*
90-283	Immune globulin (IgIV), human, for iv use
90-371	Hepatitis B immune globulin, human, for im use
90-378	RSV, monoclonal antibody, for im use, 50mg, each
90-389	Tetanus immune globulin, human, for im use
Vaccines	More than 80 different vaccines/codes. Reported with administration codes 90460-90474
90-460	Immunization administration through 18 years of age via any route of administration, with counseling by physician; first or only component of each vaccine or toxoid administered
90-461	; each additional, vaccine or toxoid component, administered, list separately. *(for a pentavalent vaccine report one unit of 99460 and 4 unit of 90461)*
90-471	Immunization administration (includes PC, ID, SQ or IM); 1 vaccine (single or combination)
90-472	; each additional (single or combination) vaccine administered
90-473	Immunization administration by intranasal oral route; 1 vaccine (single or combination vaccine/toxoid)
90-474	; each additional vaccine (single or combination vaccine/toxoid)
90-732	Pneumococcal PSV23
Psychiatry	
90-832	Psychotherapy, 30 minutes with patient
90-880	Hypnotherapy
Biofeedback	
90-901	Biofeedback training by any modality
Dialysis/ESRD	
90-935	Hemodialysis procedure with single evaluation ..
90-937	Hemodialysis procedure with repeated evaluation ..

90-945	Dialysis procedure other than hemodialysis (eg peritoneal dialysis, hemofiltration, continuous renal replacement therapies, with single evaluation
90-947	Dialysis procedure other than hemodialysis (eg peritoneal dialysis, hemofiltration, continuous renal replacement therapies, with repeated eval
90-951	ESRD related services monthly, <2 yrs …..
90-997	Hemoperfusion
Gastroenterology	
91-020	Gastric motility (manometric) studies
91-034	Esophagus, gastroesophageal reflux test, with nasal catheter Ph electrode(s) placement, recording, analysis, interpretation
91-065	Breath hydrogen or methane test
91-110	GI tract imaging, intraluminal (capsule endoscopy) ..
ENT services	
92-551	Screening test, pure tone, air only
92-552	Pure tone audiometry
92-567	Tympanometry
Cardiovascular	
92-950	Cardiopulmonary resuscitation (eg, in cardiac arrest)
92-953	Temporary transcutaneous pacing
92-960	Cardioversion, elective, external
92-928	Percutaneous transcatheter intra coronary stent placement
93-000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93-005	; tracing only, without interpretation and report
93-010	; interpretation and report only
93-040	Rhythm ECG, 1-3 leads; with interpretation and report
93-041	Rhythm ECG, 1-3 leads; tracing only, without interpretation and report
93-042	Rhythm ECG, 1-3 leads; interpretation and report only
93-224	~external ecg recording up to 48 hrs ~holter
93-303	Transthoracic ECHO for congenital abnormalities, complete
93-503	Insertion and placement of flow directed catheter (swan-ganz)
Pulmonary	
94-002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing, hospital inpatient/observation, initial day *Ventilator management codes cannot be reported with any ENM code*
94-003	Hospital inpatient/observation, each subsequent day *Ventilator management codes cannot be reported with any ENM code*
94-010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurements
94-150	Vital capacity, total
94-610	Intrapulmonary surfactant administration by through ET tube
94-460	Inhalation treatment for acute airway obstruction, or for sputum induction
94-660	CPAP initiation and management *Ventilator management codes cannot be reported with any ENM code*
94-662	Continuous negative pressure ventilation, initiation and management
94-664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, MDI or IPPB device

94-667	Manipulation of chest wall, percussing/vibrating, initial demonstration/eval
94-669	Mechanical chest wall oscillation
94-760	Non invasive ear or pulse oximetry, single determination
94-761	Multiple determinations
94-774	Pediatric home apnea monitoring ……per 30 dayqq
94-780	Car seat testing…..; first 60 minutes
Allergy immunology	
95-004	Percutaneous tests ……
95-076	Ingestion challenge test ….
95-115	Allergen immunotherapy, professional services
Endocrinology	
95-250	Ambulatory continuous glucose monitoring ….
Neurology	
95-806	Sleep study, …….
95-812	EEG, extended monitoring, 41-60 minutes
95-860	Needle electromyography
95-907	Nerve conduction studies
95-940	Intraoperative neurophysiology testing
95-992	Canalith repositioning procedure(s), (eg epley maneuver)
Genetic counseling	
96-041	Medical genetics and genetic counseling services , each 30 minutes , FTF
Behavioral screen	
96-110	Developmental screening, with scoring and documentation ….
96-127	Brief emotional/behavioral assessment (depression, ADHD) with scoring….
Injections, infusions	
96-360	IV infusion, hydration…
96-365	IV infusion for therapy, prophylaxis or diagnosis
96-369	SQ infusion therapy
96-413	Chemotherapy administration, iv
96-450	Chemotherapy administration, in to CNS (intratecheal)
Photodynamic/Derm	
96-567	Photodynamic therapy ….
Physical Med, Rehab	
97-010	Application of a modality, hot or cold packs
97-014	Electrical stimulation
97-026	Infrared
97-035	Ultrasound
Wound care	
97-602	Removal of devitalized tissues from wound …..
97-605	Negative pressure wound therapy
Nutrition therapy	
97-802	Medical nutrition therapy, initial assessment and intervention, FTF, each 15 min
Acupuncture	
97-810	Acupuncture, 1 or more needles ……
Osteopathic Manipul	
98-925	Osteopathic manipulative treatment …..

Chiropractic Manipul	
98-940	Chiropractic manipulative treatment …..
Self-Management	
98-960	Education and training for patient self-management ……
Special services	
99-026	Hospital mandated on call service, in hospital, each hour
99-050	Services in the office at times other than regularly scheduled office hours, when office is normally closed, in addition to the basic service
99-058	Services provided on an emergency basis in the office, disrupting other scheduled services, in addition to the basic service
99-070	Supplies and materials provided by physician
99-071	Educational supplies at cost to physician
99-082	Unusual travel (transportation and escort of patient)
99-173	Screening test of visual acuity, quantitative, bilateral
Anesth Qualifiers	
99-100	Anesthesia for patients of extreme age, younger than 1, older than 70 *(add on code)*
99-140	Anesthesia complicated by emergency conditions *(add on code)*
Moderate Sedation	
99-151	Moderate sedation, same physician; initial 15 minutes intraservice time, <5 yrs
99-152	; initial 15 minutes itraservice time, 5 years and older
99-153	; each additional 15 minutes itraservice time
99-155	Moderate sedation, diff physicians; initial 15 minutes intraservice time, <5 yrs
99-156	; initial 15 minutes itraservice time, 5 years and older
99-157	; each additional 15 minutes itraservice time
99-170	Anogenital examination, magnified, in childhood for suspected trauma, including image recording when performed
Other services	
99-173	Screening test of visual acuity …..
99-184	Initiation of selective head or total body hypothermia in the critically ill neonate (once per hospital stay)
99-188	Application of topical fluoride
99-195	Phlebotomy, therapeutic

CHAPTER 6 - NCCI EDITS AND MODIFIERS

Coding edits apply when a provider reports more than one claim for a patient. If there is one claim for one patient on one day, there is no problem, and no edit is needed. The potential problem arises when there are multiple claims for a single day. Payers want to ensure they are not paying for duplicate or unnecessary services and use edits to deny these claims. Most of the modifiers were developed to address this problem and inform payers that additional CPT codes were actually performed and not billed in error.

Examples: you saw a 2-year-old for a well-child check and billed 99492, but the patient also had AOM and you prescribed antibiotics and arranged follow-up. You already billed 99492 for that day. If you also bill 99213 for an AOM sick visit, the payer may think it was reported by mistake and deny it. Actually, this action may be performed by software, and one of your 2 CPT codes may be denied. This is called coding edits. When reported together, some codes are mutually exclusive. For some code pairs, there is no way to override the edit. Which means some codes can never be reported with others. For some other code pairs, coding edits can be overridden by a modifier. Back to our example, if you add modifier 25 to the second CPT code, 99213, it will tell the payer that this service is a significant, separately identifiable E/M service, and both of your claims will be accepted.

Many different modifiers exist to override or bypass these coding edits and tell payers that these are not unnecessary, duplicate, or accidental services, but are actually needed for patient care. Most physicians have minimal knowledge of modifiers. Typically, coders take care of modifiers.

NCCI (National Correct Coding Initiative) edits, developed by CMS, set the standard for the entire healthcare industry. There are 2 types of edits. The first type, which was already explained above, is procedure-to-procedure edits. You can Google “NCCI procedure to procedure” or go to its website

https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits . You need to download an Excel file to look up code pairs on this website, or go to https://www.cgsmedicare.com/medicare_dynamic/j15/ptpb/ptp/ptp.aspx . On the second website, you only need to enter the code you want to know about. Then the software will list all the mutually exclusive codes for that given code. If a code is not in the list (no pairing), then they may be both reportable, although there may be other rules about the code pair that are not covered in NCCI edits. Even if not in the list, when you report 2 different E/M services on the same day, it is still recommended to use modifier 25.

Example: you saw a well newborn and billed 99460. Baby got sick the same day, and you admitted the baby to the floor. The question is: can you report both 99460 normal newborn care and 99223 admissions to inpatient care on the same day? Well, let’s figure it out. Let’s go to the NCCI edit website and enter 99460 into the search box. The software will display a long list of CPT codes that may not be reportable with 99460. After each code pair, the system displays a 0 or a 1. If zero is displayed, it means there is no way to bypass this edit, and these 2 codes are never reported together. If 1 is displayed, then you can bypass the edit and report both codes with a modifier. To our luck, 99223 is not even on the list of 99460; this means you should be able to report both 99460 and 99223 on the same day without any problem or modifier. But this is where the system's complexity begins, because the NCCI edit is not the end of the story. The AAP coding book specifically states that the same physician cannot use normal newborn codes, such as 99460, with hospital codes, such as 99223, on the same day. The source of this

bundling is not clarified in the AAP book, but it is likely because both codes are considered initial care codes.

You had a 3-month-old patient with bronchiolitis that you billed 99233 in the morning. In the afternoon, the patient got worse and was intubated. Now you need to bill 99471. But can you report both 99233 and 99471 on the same day? If you look at the NCCI edit, you see that 99233 and 99471 are not paired, which means these 2 codes can be billed on the same day. Modifier 25 still needs to be attached to 99471 to indicate that it is a separate service from 99233.

In another example, let's say your hospitalist colleague in the same physician group admitted a patient with CPT code 99223 at 4 am. You rounded around at noon and billed 99233. Can these 2 codes be reported on the same patient on the same day? According to the code definitions, 99233 is not reportable because it is not a subsequent day yet. Because of this, if you use NCCI edit and look at the code pair 99223 - 99233, you will see that a zero number is displayed next to the pair, meaning these codes can never be reported together, and no modifier will bypass this block.

Another example: you performed 2 incision and drainage procedures, one on the left and one on the right leg. One was complex I&D, and the other was simple. CPT code for simple I&D is 10060, and CPT code for complex I&D is 10061. Per CPT, simple I&D is a component of complex I&D, so if you report them together, your claim may be denied. So let's ask NCCI edit. Let's go to the website and enter 10061 into the search box. You will see the code pair, 10061 and 10060, and the next box will display 1. This means that you can bypass this edit with a modifier. Appropriate modifier would be 59, which means distinct procedural service (a different site/organ system, separate incision or excision, separate lesion). So, in our example, we can report both I&D procedures by attaching modifier 59 to 10060, since we told the payer they are separate procedures.

Another type of NCCI edit is called a medical unlikely edit. This is simply a cap on the number of units of a procedure you can report on a given day. There is a long list of modifiers, but most are related to surgical procedures. Most pediatricians need to know only a few. Interested readers may find more information on modifiers in the CPT code book or the AAP Coding for Pediatrics book.

Modifier 25: significant, separately identifiable E/M service by the same provider on the same day of the procedure or service. It is probably the single most important modifier for most pediatricians. Any time you report more than one E/M service code for the same day, consider using modifier 25. For example, if you uncover that the patient's asthma is getting worse and start the patient on controller during a well-child check, then you should report both WCC code and sick code with modifier 25.

You saw a patient in the office in the morning for URI, which you billed 99212. If the same patient returns in the afternoon for a fractured arm, you can report this service using an appropriate office code, such as 99213, and modifier 25.

Modifier 22 is used for procedural services that take longer than usual, such as spending 45 minutes putting a couple of stitches in the wound of a combative 2-year-old. Given the difficulty of the procedure, modifier 22 may help increase RVUs and hence revenue.

Modifier 24 is used to report unrelated E/M service in the post-operative or procedure period and is mostly used by surgeons.

Modifier 26: professional component. It is used by radiologists and other physicians when reporting the findings of a test or imaging study. Like a cardiologist reporting an EKG or ECHO findings.

Modifier 59: distinct procedural service is used to bypass NCCI edits

Modifier 63: procedure performed on an infant less than 4kg. Given the difficulty of the procedure, modifier 63 may help increase RVUs and hence revenue.

Modifier 91: repeat clinical diagnostic test

Modifier 93: synchronous telemedicine service, audio only. May be used with regular office codes.

Modifier 95: synchronous telemedicine service, audio-video. May be used with regular office codes.

CHAPTER 7 - MEDICAL DOCUMENTATION

A patient note has many different functions. First of all, it's a potential medico-legal document. From this perspective, the more detailed the note you write, the better it is because in the setting of a medico-legal case, it is close to impossible to remember anything in detail. A well-written, detailed note is the best defense you can ever have. It is strongly recommended that a neutral, professional tone be used when writing medical notes. You never know which of your notes will be reviewed by lawyers to find information to attack you and other people, including your colleagues. A wide differential diagnosis is always fine, but providers should refrain from unsupported speculation. It is important to document the words exactly as spoken by the caregivers rather than summarizing them in the note. If you see any red flags that suggest potential medico-legal issues, such as complex social situations or friction between providers and caregivers, it is a good idea to write a detailed, neutral note based on the available facts.

The second function of the note is that it is probably the best communication tool in the healthcare system. A well-written, short note is a much better communication tool than long conversations or long, obscure notes, as everyone can refer to it at any time, keeping every member of the team on the same page.

Billing is yet another function of a medical note. To obtain appropriate reimbursement, medical documentation should support the reported ICD and CPT codes. For example, if you bill level 5 in the office but only document a simple URI with no extensive time, labs, or high risk, then your claim will be denied.

Like code selection, medical documentation can also be based on MDM or total time. Code selection and documentation should align, which means if you base your code selection on MDM, then your documentation should also be MDM-based. If you select the code based on time, then the documentation should also be based on time.

1-DOCUMENTING MDM-BASED CODES

MDM-based documentation of an MDM-based code

There are only 2 things to document

1-Medically appropriate history and/or examination

2- Level of MDM

Please note that it is up to the physician to decide how much history and/or examination are documented. Please also note the wording in the CPT code "*history and/or examination*". It is up to the physician to document either history, examination or both. Just document what is medically necessary or appropriate for that encounter.

If you select a high level of MDM, you should document a patient or clinical situation that qualifies for that level. If you select a high-level code like 99215 and document low-level MDM, then your claim will be denied unless you select the 99215 based on time.

You are not mandated and do not need to document how much time is spent with the patient if you are basing the code selection on patient complexity or MDM level. You may ask: What if I base my code

selection on MDM and also include total time in the note? Is there any harm in doing both? Answer is: potentially yes. Time is irrelevant in MDM-based billing, and it's okay to document time as long as the time and the billed level correlate. But if there is a discrepancy between the MDM level you have chosen and the time you spent, an inexperienced auditor may erroneously downgrade your billing to a lower level.

As an example, let's say you saw a sick, complex patient on the floor and billed 99233 based on MDM/complexity. If you document in your note that you spend 25 minutes for patient care, the auditor may think "*25 minutes qualifies only for 99231!*" and may deny your 99233, because 99233 requires 50 minutes or more of care time. An auditor should not do this, but this may happen. You can have a similar situation in the office: billing 99215 and documenting 20 minutes of time, which is discordant with the 99215 time of 40 minutes. Because of this, one does not need to document time when code selection is based on MDM, especially if you are going to document a care time that is lower than the time associated with that code.

Please refer to Chapter 2 on MDM and practical tips on MDM selection. When a certain level of MDM is selected, you should document at least 2 elements high enough for that level. Consider using the terminology used in the MDM description to make it clear which MDM element level you are talking about. For example, in the problem category, if you use the term acute life-threatening illness or severe exacerbation, this makes the auditor think about high-level MDM or the highest level code.

Problem element

If you use the terms acute stable/uncomplicated illness/injury, that implies low MDM.

If you use the terms acute illness with systemic symptoms or complicated injury, it implies moderate MDM.

For any chronic disease which is not under good control (within the target goal), use the term chronic disease with exacerbation

Data element

Document if you obtained history or interval history from caregivers for independent historian. For example, *"history is obtained from mother ……."*

Document any external notes you reviewed. Example, *"neurologist's note reviewed, which recommended brain MRI and LP"*

Document reviewed labs. Example, *"I reviewed labs and imaging, CBC within normal, CRP and procalcitonin elevated, CMP within normal, lipase elevated."*

Independent interpretation of tests. Example, *"My independent interpretation of CXR: hyperinflation with perihilar infiltrates."*

Discussion management. Example, *"I discussed management with the gastroenterologist and started the patient on PPI and H2 blocker, and arranged endoscopy for tomorrow."*

Risk element

Prescription drug management aligns with moderate level MDM. Document in your note that you prescribed or renewed the medication for a specific condition. Just listing of medication and condition by the software is not acceptable. Example, "*Fluticasone inhaler renewed for well-controlled chronic asthma*"

Diagnosis or treatment significantly limited by social determinants of health aligns with moderate level MDM. Document in your note that the patient's social factors made it more difficult for you to evaluate and manage the patient's problems.

Drug therapy requiring intensive monitoring for toxicity aligns with high-level MDM. It may be reasonable to use the above wording exactly to let a potential auditor know that the patient has high-risk MDM. Example, *"patient needs weekly LFTs while on methimazole for monitoring for hepatotoxicity (Drug therapy requiring intensive monitoring for toxicity)."*

Decision regarding hospitalization or escalation of hospital-level care aligns with high-level MDM. Document your decision regarding hospitalization. Example: *"Given that the patient is hypoxemic and requires supplemental oxygen through HFNC, we will admit the patient."*

Use of **parenteral controlled substances** aligns with high-level MDM. Document the need and usage of the controlled substance. Example, "patient has not responded to acetaminophen and ibuprofen for pain and was started on IV morphine", "patient was given IV diazepam for muscle spasm"

The decision not to resuscitate or to de-escalate care because of poor prognosis aligns with high-level MDM. Document the discussion on DNR, DNI, or de-escalation of care.

Time-based documentation of an MDM-based code

You need to document 2 things.

1-Medically appropriate history and/or examination

2- Details and duration of total time spent for patient care

Prior to 2022/2023, you could only base code selection on time when the dominant part of the service was counseling and coordination of care. This is why old attestations universally stated "***more than 50% of my time spent in counseling and coordination of care***." Furthermore, only the time spent in the room, face-to-face with the patient, counted, not your 20 minutes of chart review before seeing the patient. It all changed in 2022/2023: now almost everything you do for patient care counts toward the total time, and you can base code selection on time at any time you like, regardless of counseling and coordination of care, so you no longer need the old attestation. You also don't need to be face-to-face with the patient for the time to count. You could be off the patient's floor or out of the office, and time still counts. Activities listed below count toward the total time.

1. Preparing to see the patient: **chart review, review of tests.**
2. Obtaining and/or reviewing separately obtained **history.**

3. Performing a medically appropriate **examination and/or evaluation.**
4. **Ordering** medications, tests, or procedures.
5. **Counseling** and educating the patient/family-caregiver.
6. **Referring and communicating** with other health care professionals.
7. **Coordination** of care.
8. **Documenting** clinical information in the electronic or other health record ~ writing notes.
9. Independently **interpreting results** and communicating results to the patient/family.

Do not count time spent on the following:

The performance of other services that are reported separately under another CPT code. For example, providing procedural sedation and billing 99233. Because procedural sedation is reported with another CPT code, the time spent on procedural sedation is not counted toward the total time of the E/M service code, such as 99233.

Teaching that is general and not limited to discussion that is required for the management of a specific patient.

You are not expected to document every little detail on how you spent the time, including every conversation, but document the main points about how that time is spent. Instead of documenting "management was discussed with endocrinologist" you can write "management was discussed with endocrinologist who recommended a repeat HBA1c, close glucose monitoring, and higher dose of long-acting insulin."

You can create an attestation, like this: *"I spent X minutes for this patient, including chart review, review of labs, imaging, orders, history, examination, management discussions with X, education/counseling on X, and medical documentation."* Or *"total time spent for patient care is X minutes, including ……"*

2-DOCUMENTING NON-MDM BASED CODES (NORMAL NEWBORN, DISCHARGE, WCC)

These include hospital discharge day care services, normal newborn services, and preventative care/WCC codes. There is no mandatory amount of time or data needed to be documented for these codes, other than documenting time for hospital discharge codes. You should document the time spent on the day of discharge, because less than 30 minutes means 99238 and more than 30 minutes means 99239. While documenting for non-MDM-based codes, include whatever information is appropriate for that encounter.

3-DOCUMENTING CRITICAL CARE CODES

Documentation of critical care codes is more complex because one must document both a critical illness/care, as defined by CPT, and a high-level MDM. Critical illness and care are defined by CPT as follows:

"A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability *of imminent or life-threatening deterioration in the patient's condition."*

"Critical care involves high complexity medical decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition."

Based on these definitions, 4 points need to be documented in critical care notes. The 5th point (total time spent) applies only to time-based critical care notes, as these codes are based on time.

1- Acute, vital organ impairment

2- High probability of deterioration, either imminent or life-threatening

3- Assessment, manipulation, and support of vital system function

4- High complexity medical decision making

5- Total time spent (only for time-based critical care codes, 99291, 99292.)

The first requirement is documentation of critical illness, as defined by CPT. Based on the above definition, one should document impairment or failure of one vital organ and a high probability of deterioration. Otherwise, the patient may not be considered critically ill by the payers. If there is no acute vital organ impairment or failure, then there is no critical illness.

When documenting critical care, always document high-level MDM, because if patient management doesn't qualify for high-level MDM, it is not considered critical care from the CPT perspective. So, it is mandatory to document high-level MDM for critical care codes. Most critically ill patients should easily qualify for high-level MDM given the high-risk, high-acuity problems they frequently have, but it is important to document it. Providers should also consider documenting assessment, manipulation, and support of vital system functions as indicated, as these criteria are listed in the definition of critical care.

Apart from high-level MDM, time also needs to be documented when time-based or adult critical care codes are reported (99291, 99292). It is mandatory to document time spent, as these codes are time-based. When day-based or pediatric/neonatal critical care codes are reported, then documentation of time is optional. If documented, though the total time should not be less than 30 minutes, because per CPT, care that is less than 30 minutes is not considered critical care.

4-DOCUMENTING CONSULTATION CODES

It's recommended that when 2 providers report services for the same patient on the same day, they select different ICD codes to show that they are managing different parts of patient care. The claim of the second provider might be denied if the same ICD codes are used. For example, if a consultant lists the same ICD codes as the primary attending requesting the consult, the consultant's claim might be automatically denied, or it may trigger a review by the payer to ensure that services are not redundant

or duplicative. The request and the reason for consultation should be documented in the requester's or the consultant's note, or in a written order.

5-DOCUMENTING ICD CODES.

CPT codes are always reported with ICD codes. ICD codes tell the payer about the reason for service, while CPT codes tell the payer about the nature of the service. You should align your CPT codes with ICD codes. You should not just select the ICD code; you should also document it clearly in your note. You can select an ICD code for severe asthma exacerbation, but if you don't describe it in your note that the patient had severe asthma exacerbation or if you document a patient who has only mild asthma exacerbation, then your claim for the highest level code may be denied.

If you report high-level codes, list sicker-looking ICD codes, unless time-based billing is used. For example, if the sicket ICD code listed is URI, it may be difficult to justify code 99223, and the claim may be denied; however, it will likely be reimbursed if severe RAD exacerbation is used. If critical care codes are reported, the first listed ICD code should be a critical illness code.

For MDM-based codes, reported ICD codes should preferably reflect the patient's active problems being addressed, not inactive problems that are not addressed at that encounter. This is because chronic problems, if not contributing to medical decision-making, are not relevant in selecting the level of MDM. Although ICD for unaddressed chronic problems may be listed, they are not as important as the acute problems for MDM-based billing. If you are reporting higher-level codes, then list the appropriate sick ICD codes first, before unaddressed chronic problems.

6-DOCUMENTTAION REQUIREMENTS FOR TEACHING PHYSICIANS

Non-critical care notes

From the billing perspective, there are only 2 things that teaching physicians must document when attesting a resident or fellow note. First, documentation should make it clear that the teaching physician actually/physically saw the patient. *"I saw the patient"* or *"I saw and evaluated the patient"* or any similar sentence that makes it clear that you physically saw the patient is enough. Second, you should document that you participated in patient management (resident's note/plan). *"I agree with the resident note"* or any similar sentence is enough.

First comment: *"I saw the patient"* is needed because if you did not see the patient, you can't bill most CPT codes. Second comment *"I agree with the resident note"* is needed because without this comment, you can't own the resident note for documentation purposes. If the resident or fellow note has an appropriate level of documentation for the level of billing that you will report, then you do not need to write anything else. Your attestation on the resident note would be enough. All non-critical care note attestations can be a universal attestation with no patient-specific information, since you are only required to document that you saw the patient and agree with the resident note.

If the resident note doesn't contain sufficient documentation for the level you are targeting, you should either ask the resident to provide more detailed documentation or include the relevant documentation in your attestation.

Example of acceptable attestation. *"I saw and evaluated the patient. I reviewed the resident note and agree with the resident findings and plan of care"* or *"I saw the patient and agree with the resident note except that pain is still poorly controlled and we will add IV morphine prn."*

Unacceptable attestation examples: *"agree with above", "rounded, reviewed, agree", "discussed with resident"*. These are not acceptable because it is unclear whether the teaching physician saw the patient. *"Patient seen and evaluated"* is not acceptable because it is unclear whether the teaching physician agrees with the resident's note or contributed to the plan of care.

For MDM-based codes, when the teaching physician bases code selection on time, then the resident's note becomes less important from the billing perspective. This is because, regardless of the resident note, the teaching physician should still document the time spent on patient care and how it is spent. Although the resident note can be used to document care details, the teaching physician should still personally document the time spent.

Critical care notes

Critical care note attestations require 4 additional comments, in addition to the 2 above (I saw the patient and agree with the resident note). Because 3 of the 4 comments are patient-specific, critical care attestation can't be a universal attestation and should always include patient-specific information.

Additional documentation

1) Patient was critically ill.

2) What made the patient critically ill?

3) Treatment/management provided by the teaching physician.

4) Time teaching physician spent (only applies to time-based critical care codes).

Example of acceptable critical care attestation. *"Patient developed hypotension and hypoxia. I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation, and I agree with the resident's assessment and plan of care."*

Example of unacceptable critical care attestation. *"I came and saw the patient and agree with the resident."*

Procedural notes

For minor surgical procedures (intubation, central line, LP, endoscopy), the teaching physician should document in the attestation that the teaching physician was present for the entire procedure.

Example of teaching physician attestation of LP*: "I supervised the LP and was present for the entire procedure."* This is enough documentation to own the resident procedure note and report the CPT code for LP under your name.

For a major surgical procedure, the teaching physician attestation should document that the teaching physician was present for key portion(s) of the procedure.

CHAPTER 8 - HOW TO MAXIMIZE REVENUE GENERATION IN THE OFFICE?

A review of previous chapters, especially chapters 3 and 4, is strongly recommended before reading this chapter, as it lays the foundations for optimal billing and documentation. Maximizing revenue generation is an important consideration for both private practice and academic physicians. There are many ways to maximize revenue generation. We will take a detailed look at each one.

1-AIM FOR THE HIGEST POSSIBLE LEVEL IN AN MDM-BASED CODE SET

The highest-level codes, also known as level 5 in the office, are 99205, 99215, and 99245. As explained in Chapter 2, there are 2 different ways to get to level 5. The first one uses total time, and the second uses MDM. You should always look at how much total time you have spent first. If you have spent enough time to meet the requirement for the highest level in a code set, then you should not bother looking at MDM, because, irrespective of MDM, you can report the highest level of code. If the total time you spend with the patient is insufficient for the highest level, you should check whether the MDM is sufficient to reach a higher level. This is the golden rule. Use the pathway that gives you the highest level. You may not be able to turn level 2 into level 5 unless you spend enough time, but turning level 2 into level 3 or turning level 3 into level 4 may not be too difficult.

Total time for level 5 is 60 minutes for a new patient (99205), 40 minutes for an established patient (99215) and 55 minutes for office consultation (99245).

MDM-based E/M service codes for office use.

Code Set	CPT code	Code level	Time	MDM level
Office New Patient	99202	Level 2	15 minutes	Straightforward
	99203	Level 3	30 minutes	low
	99204	Level 4	45 minutes	Moderate
	99205	Level 5	60 minutes	High
Office Established	99212	Level 2	10 minutes	Straightforward
	99213	Level 3	20 minutes	low
	99214	Level 4	30 minutes	Moderate
	99215	Level 5	40 minutes	High
Consult	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	low
	99244	Level 4	40 minutes	moderate
	99245	Level 5	55 minutes	High

Almost everything that you do for patient care that is not reported with another CPT code is included in the total time. You don't need to be in the office or with the patient for the time to count.

1. Preparing to see the patient: **chart review, review of tests**.
2. Obtaining and/or reviewing separately obtained **history.**
3. Performing a medically appropriate **examination and/or evaluation.**
4. **Ordering** medications, tests, or procedures.
5. **Counseling** and educating the patient/family-caregiver.
6. **Referring and communicating** with other health care professionals.
7. **Coordination** of care.
8. **Documenting** clinical information in the electronic or other health record ~ writing notes .
9. Independently **interpreting results** and communicating results to the patient/family.

Example: the highest level in the clinic for an established patient has a total time of 40 minutes. If you spend 40 minutes with an established patient, then you should bill level 5 (99215) irrespective of complexity/MDM. What if you spend only 20 minutes with an established patient, which only qualifies for level 3 (99213)? Can you make it to level 4 or 5 using MDM? If the answer is yes, *"based on MDM I can report level 4",* then report level 4 based on MDM. If MDM only qualifies level 2, then report level 3 based on total time.

Physicians tend to underestimate their time, but it's important to remember that everything you do for patient care counts toward total time, including writing your note. If your established patients have 30-minute face-to-face appointment slots, then you should probably bill level 5 because if you consider the time to review patient's chart before or after the encounter, plus time to write the note, it will probably take another 10 minutes, hence 40-minute total time, which will give you level 5. If your new patient or consultation time slot is 1 hour, then you should bill the level 5 code.

Never forget that you can increase the total time spent on patient care in various ways, including providing counseling or education, coordinating care, calling consultants, etc. Let's say you spent 10 minutes on an established patient with a diaper rash, which typically qualifies for level 2 or level 3 at most. You can still bill level 5 if you spent another 30 minutes teaching the family how to prevent and manage diaper rash. You should, of course, document your extended talk/education in the chart; otherwise, your level 5 claim will be rejected because diaper rash is not a typical level 5 problem.

It is important to note that spending more time to reach a higher level does not work for well-child check codes, because these codes are based on encounters, not on time or MDM. Whether you spend 1 hour or 10 minutes doesn't affect the reported CPT code. So you cannot generate more revenue by providing extra anticipatory guidance during a well-child check.

There is a significant problem with time-based billing for revenue generation. If you target the highest code level with time, then you can only see a handful of patients. For example, if you work nonstop from 8 am to 5 pm, which is 9 hours, you can only bill for 9 level 5 new patients or 13 level 5 established patients, based on time. Although you may bill the highest level, you will not generate much revenue because you are billing only for a few patients per day.

Medi-Cal pays $19.75 for a level 2 established patient (10 minutes) and $62 for a level 5 established patient (40 minutes). So if you consider an 80-minute time period, you will be able to see only 2 level 5 patients (40 minutes each) and generate $124 in revenue. If you see 8 level 2 patients (10 minutes each), you can generate $160, which is more than $ 124. So it is clear that if you see many simple patients, you may end up generating more revenue than if you see a few complex patients.

MDM-based billing is very valuable for revenue generation for exactly the same above reason, as you can bill high levels even when you spend a few minutes with the patient, because when you base your code selection on MDM, then how much time you spend with the patient is not important or simply irrelevant. It is difficult to reach level 5 using MDM, but level 4 is not too difficult to reach. Any time you prescribe or continue medication to a chronic patient that is not within the target treatment goal, then you can bill level 4 even if you spend 5 minutes with the patient. Seeing a lot of patients every 10-15 minutes and billing level 3 or 4 based on MDM is probably the best overall strategy for maximal revenue generation, of course, if you have enough patient volume or complexity. This is probably the reason why 99214 is the most frequently reported code in the office code sets.

We have seen above that by spending more time or care, you can increase the code level and hence revenue generation. Can a similar strategy work in the MDM pathway? The answer is yes, but instead of time, you should identify additional problems, data, or risks to increase the MDM level.

There will be many patients with 1 self-limited or minor problem in the clinic, like a simple URI. These patients only qualify for level 2 based on MDM, but you can change them to level 3 if you can identify and address other problems. For example, a simple URI is typically a level 2 problem, but you can turn it into level 3 billing if you find a diaper rash and address it. This is because 1 self-limited or minor problem qualifies for level 2, but 2 such problems qualify for level 3 with an independent historian. Another example is for chronic diseases. If you address 1 stable, chronic illness, this qualifies for level 3 with an independent historian, but if you address 2 stable chronic illnesses, it can qualify for level 4 if you write or renew a prescription. By addressing more problems, you can increase revenue generation. Example: you are seeing a patient with stable ADHD in the clinic. By addressing patient stable eczema, you can turn level 3 billing into level 4 billing. Your documentation should reflect what you did for these 2 conditions.

Use the details about MDM elements from Chapter 2 to target the highest level of code. One high-yield combination is a combination of one **chronic illness with exacerbation or progression,** plus **prescription drug management**. Any chronic illness that is not within treatment goal targets fits into this category. Any time you prescribe or renew a prescription, this is called prescription drug management. This combination will get you to level 4, which is not difficult to reach. Example: you see a patient in the clinic with acne that is not well controlled, and prescribe the previous medication or add a new one.

The sicker the patient or the more complex the problem, the higher the level you can target. Acute life-threatening illness > complicated acute illness with complication > uncomplicated acute illness > self-limited or minor problem. Severe exacerbation of chronic illness > exacerbation of chronic illness > stable chronic illness.

Another way of increasing MDM and hence billing at a higher level is by ordering more labs or imaging. Medically appropriate labs and imaging will help you get to the highest level. For example, if you have an independent historian and 2 labs (CBC, BMP), then this patient qualifies for level 4 if you are prescribing a medication, irrespective of the problem. If you add one independent interpretation of CXR, this qualifies for level 5 billing if you have an appropriate problem. Example: You have seen a patient with a large VSD and started the patient on Lasix. If you order CBC, BMP, independently interpret CXR, and monthly BMP for electrolyte monitoring, then this patient qualifies for level 5 billing because both data and risk elements is high enough for high MDM. In this example, monthly BMP to monitor side effects of Lasix qualifies for high-risk (intense drug monitoring).

The last way to target a higher MDM, hence a higher code level, is to use the risk element. Prescription drug management and social limiting factors qualify for level 4 billing. Drug therapy requiring intensive monitoring for toxicity, decision regarding hospitalization, or escalation of hospital-level care qualifies for level 5 billing.

Summary of targeting higher levels in a code set

Time based higher level code targeting	
Spend more time *(that is medically appropriate)*	Provide counseling, education, address concerns in length
	Coordination of care~ talk with consultants
	More detailed chart review
	More detailed history, examination *(medically appropriate)*
	Writing more detailed notes

MDM based higher level code targeting	
Problems. *Address more problems or more complex problems*	1 self-limited or minor problem < 2 self-limited or minor problem
	1 stable chronic illnesses < 2 stable chronic illnesses
	Stable chronic illnesses < chronic illness with exacerbation < chronic illness with severe exacerbation
	Acute, uncomplicated illness < acute illness with systemic symptoms < acute life threatening illness
Data *Order and review more medically appropriate data elements*	Have independent historian
	Order and review more tests
	Review external notes
	Provide independent interpretation of tests or imaging
	Management discussions with other providers
Risks	Prescription drug management *(giving or renewing prescription)*
	Diagnosis or treatment significantly limited by social determinants of health
	Drug therapy requiring intensive monitoring for toxicity
	Decision regarding hospitalization or escalation of hospital-level care

2- USE PROLONGED CARE CODES

Please refer to Chapter 3 for details on prolonged care codes. There are basically 2 different types of prolonged care codes. The first code group consist of 99417 and 99418, and only 99417 is used in the outpatient setting. It is used when you see a patient and then spend too much time with the patient during the same day/date. Second code group 99358 and 993569 is to report extra time for the patient care on the day/date that you have not seen the patient. These code sets exist so that you can bill, for example, extra time for reviving a discharged neonatal ICU patient's chart 2 days prior to the appointment, or for talking with a neurologist after the patient's MRI is back, on a day when you have not seen the patient.

99417 is for each 15-minute block. 99358 is for the first hour, and 99359 is for each additional 30 minutes.

Typical things that may count toward prolonged time include prolonged face-to-face care time, like an asthma exacerbation in the clinic requiring multiple evaluations/nebs, counselling, education, coordination of care, like calling the insurance company for a denial, chart review, interpretation of the labs or imaging, talking with other providers, writing notes/reports.

3-CONSULTING ON A PATIENT WITHOUT SEEING THE PATIENT

There are many instances in which a consultant spends a lot of time on the phone for patient care but does not see the patient that day. In this instance, the consultants can report their time spent on that day using prolonged care codes 99358 and 99359, as long as they see the patient in the following days.

4-PREVENTETIVE MEDICINE SERVICE ARE ONLY FOR WELL CHILD CHECKS AND NOT FOR SICK VISISTS

Preventive medicine code sets 99381-99384 and 99391-99394 are only for well-child checks. If any significant problem is identified and addressed during the encounter, it should be reported with appropriate E/M service codes using modifier 25. Modifier 25 lets the payer know that management of the problem was a separate service. An insignificant or trivial problem identified during a well check is included in the well check and not separately reported.

For example, if you see a six-year-old for WCC and discover that his asthma is poorly controlled, you can provide asthma management in addition to WCC and report both the WCC code and the sick office visit code.

5- MEDICAL TEAM CONFERENCE

Please refer to Chapter 3 for details on the medical team conference (team meeting). Office physicians or consulting physicians may report their time using an appropriate E/M service code, such as 99233, and use prolonged care codes if needed when a family member or patient is present during the meeting. When a family member or caregiver is not present in the meeting, then code 99367 can be billed.

6-OTHER E/M SERVICES

Report other E/M services when you provide them, like telemedicine codes or online digital E/M services, interprofessional telephone/internet/electronic health record consultation, digitally stored data services/remote physiologic monitoring, and advanced care planning services.

7- CRITICAL CARE SERVICES

Although rare, if you manage a critically ill patient in the office prior to transfer to the hospital, you may report time-based critical care codes if the time spent is more than 30 minutes. Example: one of your patients had severe anaphylaxis or severe asthma exacerbation in the clinic, and you provided 40 minutes of care, gave epinephrine and albuterol nebs, then you may bill 99291 irrespective of age.

8- DO NOT FOGET NON-E/M SERVICES OR PROCEDURES

E/M services or codes only cover evaluation and management. They basically involve examination and talking. If you perform anything other than examination or talking, there can be a separate code for it. For example, an ear exam is part of the physical examination and, hence, part of normal E/M service, but removal of impacted cerumen is not. There is a separate code for impacted cerumen removal; if you perform one, report it separately.

What non-E/M services an office physician may report heavily depends on specialty and subspecialty. Examples are vaccination codes, wart removal codes, and reduction of nursemaid's elbow. It is strongly recommended that physicians scroll through the pages of a CPT code book, find relevant codes for their practice, and use them to generate more revenue. You will be surprised by how many procedures you are already performing that are separately reportable. Chapter 4 provides useful information on common non-E/M service codes used by pediatricians.

9-APPROPRIATE DOCUMENTATION OF SELECTED CPT CODE

The importance of documentation cannot be overemphasized, as reimbursement doesn’t depend on delivered care but rather on documentation. If a reported CPT code (or a claim) lacks appropriate documentation, it may be denied. Please refer to section 6 for guidelines on appropriate documentation.

So, do not just select the highest level of code; also, document in your note that the patient actually qualifies for that level. If you are billing 99215, then either document high-level MDM or 40 minutes of total time.

10- APPROPIATE USE OF ICD CODES

CPT codes are always reported with ICD codes. ICD codes tell the payer about the reason for service, while CPT codes tell the payer about the nature of the service. You should align your CPT codes with ICD codes. If you report high-level codes, then you should list sicker-looking ICD codes, unless time-based

billing is used. For example, if the sickest ICD code listed is URI, it may be difficult to justify 99215, and the claim may be denied; however, it will likely be reimbursed if severe RAD exacerbation is used.

Reported ICD codes should reflect the patient's active problems being addressed, not inactive problems that are not addressed at that encounter. Chronic problems that are not contributing to medical decision-making are not relevant in selecting the level of MDM. Although ICD for unaddressed chronic problems may be listed, they are not as important as the acute problems. If you are reporting higher-level codes, list the appropriate sick ICD codes first, at the top, before ICD codes for other unaddressed chronic problems.

11- DO NOT FORGET TO BILL

Physicians frequently lose revenue when they forget to bill. It's a good idea to have a system that reminds you to bill for every patient that you see. This can be a computer-generated or handwritten patient list, with a check mark for every patient who is seen and billed. If you are a teaching physician, it's a good idea to write down the list of the patients you have seen that day so that if a resident forgets to write a note, you can still detect the missing note and bill for it. If you do not have your own list, then you may not realize when a resident forgets to place a note, especially if you are signing your notes and billing days after being on service.

12- FOLLOW YOUR CLAIMS

Follow your claims closely to ensure they are submitted appropriately and denials are addressed. If you do not have a system in place to follow your claims, then you would have no idea how much revenue you are losing.

CHAPTER 9 - HOW TO MAXIMIZE REVENUE GENERATION IN THE HOSPITAL FLOOR?

A review of previous chapters, especially chapters 3 and 4, is strongly recommended before reading this chapter, as it lays the foundations for optimal billing and documentation. Maximizing revenue generation is an important consideration for both private practice and academic physicians. There are many ways to maximize revenue generation. We would take a detailed look at each one.

1-AIM FOR THE HIGEST POSSIBLE LEVEL IN AN MDM-BASED CODE SET

The highest-level hospital codes (level 3) are 99223, 99233, and 99236. Outpatient consult codes, which are used in the ER, and inpatient consult codes have the highest level of 5. As explained in Chapter 2, there are 2 ways to reach the highest level. The first one uses total time, and the second uses MDM. You should always look at how much total time you have spent first. If you have spent enough time to meet the requirement for the highest level in a code set, then you should not bother looking at MDM, because, irrespective of MDM, you can report the highest level of code. If the total time you spent with the patient is insufficient for the highest level, you should check whether the MDM is sufficient to reach a higher level. This is the golden rule. Use the pathway that gives you the highest level. You may not be able to turn level 1 into level 3 unless you spend enough time, but turning level 1 into level 2 or turning level 2 into level 3 may not be too difficult.

MDM-based E/M service codes for floor use.

Code Set	CPT code	Code Level	Time	MDM
Admission	99221	Level 1	40 minutes	Straightforward/Low
	99222	Level 2	55 minutes	Moderate
	99223	Level3	**75 minutes**	High
Subsequent	99231	Level 1	25 minutes	Straightforward/Low
	99232	Level 2	35 minutes	Moderate
	99233	Level 3	**50 minutes**	High
Same day	99234	Level 1	45 minutes	Straightforward/Low
	99235	Level 2	70 minutes	Moderate
	99236	Level 3	**85 minutes**	High
Discharge	99238	N/A	<30 minutes	N/A
	99239	N/A	**>30 minutes**	N/A
Consult ER	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	Low
	99244	Level 4	40 minutes	Moderate
	99245	Level 5	**55 minutes**	High
Consult inpatient	99252	Level 2	35 minutes	Straightforward
	99253	Level 3	45 minutes	Low
	99254	Level 4	60 minutes	Moderate
	99255	Level 5	**80 minutes**	high

Almost everything that you do for patient care that is not reported with another CPT code is included in the total time. You don't need to be on the patient floor for the time to count.

1. Preparing to see the patient: **chart review, review of tests or imaging.**
2. Obtaining and/or reviewing separately obtained **history.**
3. Performing a medically appropriate **examination and/or evaluation.**
4. **Ordering** medications, tests, or procedures.
5. **Counseling** and educating the patient/family-caregiver.
6. **Referring and communicating** with other health care professionals.
7. **Coordination** of care.
8. **Documenting** clinical information in the electronic or other health record ~ **writing notes** .
9. Independently **interpreting results** and communicating results to the patient/family.

Example: the highest level on the floor for the subsequent patient has 50 minutes of total time. If you spend 50 minutes on a subsequent patient, then you should bill level 3 (99233) irrespective of complexity/MDM. What if you spend only 35 minutes total time with a subsequent patient, which only qualifies for level 2 (99232)? Can you make it level 3 using MDM? If the answer is yes, *"based on MDM I can report level 3",* then report level 3 based on MDM. If MDM only qualifies level 1, then report level 2 based on total time.

Physicians tend to underestimate their time, but it's important to remember that everything you do for patient care counts toward total time, including writing your note. Time spent in pre-rounding, looking at vitals, labs, imaging, and notes; talking with consultants, radiologists, dietitians, or other team members; and time spent during rounds, including answering questions from patients or caregivers, all count toward time. Time spent on unrelated teaching during the rounds does not count. Time spent looking into textbooks, journal articles, online resources, drug doses, and side effects counts towards time as long as it's done to help with patient management. For example, you had a patient with AKI and looked up all the medications that the patient is on for their side effects on the kidneys. You have a patient with white matter lesions in the brain MRI, and looked in a textbook for what differential labs to send and how to manage this condition.

You can increase the total time spent on patient care in various ways, including providing counseling or education, coordinating care, calling consultants, etc., as long as it is medically appropriate. For example, you have a patient with asthma exacerbation who is doing well and improving. If you spent only 25 minutes on this patient and the patient has low MDM, the patient only qualifies for level 1 (99231), but you can bill level 3 if you provide an additional 25 minutes of education on asthma prevention and management. 25+25=50 minutes = level 3, 99233.

It is important to note that spending more time to reach a higher level does not work for hospital discharge services when it is already more than 30 minutes, and for normal newborn services. Whether you spend 40 minutes or 4 hours on a discharge doesn't matter; you still bill the same code, 99239.

We have seen above that by spending more time, you could increase the code level and hence revenue generation. Can a similar strategy work in the MDM pathway? The answer is yes, but instead of time, you should identify additional problems, data, or risks to increase the MDM level.

The sicker the patient or the more complex the problem, higher the level you can target. Acute life-threatening illness > complicated acute illness with complication > uncomplicated acute illness > self-limited or minor problem. Severe exacerbation of chronic illness > exacerbation of chronic illness > stable chronic illness.

Consider addressing or uncovering more problems, especially patient comorbidities. Addressing comorbidities and uncovering new problems is not only a good practice but also helps increase the level of MDM and, hence, revenue generation. For example, you have a subsequent patient with soft tissue infection who is doing well and only qualifies for level 1 (99231) based on MDM. Let's assume the patient also had hypothyroidism, and you checked the TSH level, which is elevated, and you changed the levothyroxine dose. By definition, this (unstable chronic disease plus drug prescription) qualifies for moderate MDM and hence level 2 (99232). Another example would be checking a VitD level, if it is low, and you start cholecalciferol, that is level 2 billing.

In many hospitalized patients, it is not difficult to reach the highest level of data element because there are many labs, imaging, or notes to review, and each counts. The high MDM data element has 3 categories, and 2 of them must be fulfilled. The first category only needs 3 items, including any combination of labs, imaging, notes, and an independent historian. Examples of enough items: cbc/bmp/crp or cbc/crp/Ua or CBC/external note review/independent historian. Because in pediatrics, we almost always have an independent historian/caregiver, you practically end up needing 2 more. Category 2 is fulfilled any time you independently interpret a study like CXR, KUB, CT, or EKG. Category 3 is fulfilled any time you have a management discussion with other physicians. You only need 2 out of 3 categories fulfilled. For example, you interpreted the CXR and called the pulmonologist for management, which qualifies as the highest level MDM data. Then you just need to add a sufficiently high problem or risk to reach high-level MDM or the highest-level code. Ordering more tests and imaging (medically appropriate), reviewing more notes, or talking with other physicians all help reach the highest level.

Two risk examples were given for moderate MDM. First one, "prescription drug management" is very useful because when you combine it with unstable chronic disease, then it automatically qualifies for moderate MDM, level 2. For example, you have a subsequent patient with a simple soft-tissue infection that only qualifies for level 1 (99231) based on MDM. If the patient has not well-controlled DM and you continue the patient's insulin, this would automatically make the patient moderate MDM and hence level 2. With a little detail, you generated more revenue. The second risk example is "diagnosis or treatment significantly limited by social determinants of health". You can use this criterion when a patient's social factors significantly complicate evaluation and management, making management more challenging, such as living in a shelter or in a very difficult social situation.

Four high-risk examples were given for high MDM. The first one: a *decision regarding hospitalization or escalation of hospital-level care*, applies anytime you consider an admission from the ER or a transfer of a patient from the floor to the ICU. The second one, *drug therapy requiring intensive monitoring for toxicity*, applies when you have frequent labs to avoid side effects. Examples include checking daily BMPs while being NPO with IV fluids (to avoid electrolyte derangements), checking daily BMPs while on diuretics, monitoring CBC or LFTs while on drugs that cause neutropenia or hepatotoxicity, or monitoring Cr while on vancomycin. Checking EKGs while on QT-prolonging medications is also in this risk group. The third high-risk example, *parenteral controlled substances*, applies when IV opioids or benzodiazepines are used for pain or comfort. Fourth high-risk example, *decision not to resuscitate or to de-escalate care because of poor prognosis* applies during end-of-life discussions. If you have one of the above high-risk factors, you only need high-level data or a problem to qualify for the highest-level code.

Summary of targeting higher level in a code set.

Time-based higher level code targeting	
Spend more time *(that is medically appropriate)*	Provide counseling, education, address concerns in length
	Coordination of care~ talk with consultants
	More detailed chart review
	More detailed history, examination *(medically appropriate)*
	Writing more detailed notes

MDM-based higher level code targeting	
Problems. *Address more problems or more complex problems*	1 self-limited or minor problem < 2 self-limited or minor problem
	1 stable chronic illness < 2 stable chronic illnesses
	Stable chronic illnesses < chronic illness with exacerbation < chronic illness with severe exacerbation
	Acute, uncomplicated illness < acute illness with systemic symptoms < acute life threatening illness
Data *Order and review more medically appropriate data elements*	Have independent historian
	Order and review more tests, *medically appropriate*
	Review external notes
	Provide independent interpretation of tests or imaging
	Management discussions with other providers
Risks	Prescription drug management *(giving or renewing prescription)*
	Diagnosis or treatment significantly limited by social determinants of health
	Drug therapy requiring intensive monitoring for toxicity
	Decision regarding hospitalization or escalation of hospital-level care
	Decision not to resuscitate or to deescalate care because of poor prognosis
	Parenteral controlled substances

2- USE PROLONGED CARE CODES

Please refer to Chapter 3 for details on prolonged care codes. There are basically 2 different types of prolonged care codes. The first code group consists of 99417 and 99418. Only 99418 is used in an inpatient setting. It is used when you see a patient and then spend too much time with the patient during the same day/date. Second code group 99358 and 993569 is to report extra time for the patient care on the day/date that you have not seen the patient.

99418 represents each 15-minute block. This code exists so you can bill for care beyond the typical. Examples include spending several hours with a socially difficult or medically complex patient, trying to figure out what's wrong, talking with multiple consultants or spending a lot of time at the bedside.

99358 is for the first hour, and 99359 is for each additional 30 minutes. It would be rare for a hospital physician not to see their patient that day. These codes can be used in rare situations when you are involved in the care of a patient while not on service. Hospitalists who take call at home may use these codes more commonly. For example, you were called by your resident at 9pm about a new admission, spent 30 minutes on the phone that night, and saw the patient the next day. Then you can report your time using these prolonged care codes for the night when you didn't see the patient.

Prolonged care codes may be used by the night attending when they are on call and provide care to patients who become active at night. This may be an important source of revenue generation. 99418 involves 15 minutes of care. Most interactions with an active patient at night take at least 15 minutes, which is good enough to bill 99418. If you send 60 minutes, then you can report 4 units of 99418 (4 x 15 = 60). In order to report 9918 at night, though billing in the day should be either time-based 99223 or time-based 99233.

3-CONSULTING ON A PATIENT WITHOUT SEEING THE PATIENT

There are many instances in which a consultant spends a lot of time on the phone with a patient but still does not see the patient that day. In this instance, you can report your time spent on that day with prolonged care codes 99358 and 99359, as long as you see the patient in the following days or have seen the patient in the past.

4- MEDICAL TEAM CONFERENCE

Please refer to Chapter 3 for details on the medical team conference (team meeting). Hospitalists or consulting physicians may report their time using an appropriate E/M service code, such as 99233, and use prolonged care codes if needed when a family member or patient is present during the meeting. When a family member or caregiver is not present, then code 99367 can be used to report the time.

5- CRITICAL CARE SERVICES

Critical care codes are not reserved for intensivists and may be reported by any other physician. Hospitalists should strongly consider using critical care codes for patient care that meets the definition of critical care. Patients transferred to the ICU are an important group, and hospitalists can report

critical care services for the management of critically ill patients prior to transfer. Only detail is that, because the care is time-based, adult or time-based critical care codes 99291 and 99292 are used, irrespective of the patient's age, and not the pediatric/neonatal critical care codes.

6-OTHER E/M SERVICES

Report other E/M services when you provide them such as, telemedicine codes or online digital E/M services.

7- DO NOT FORGET NON-E/M SERVICES OR PROCEDURES

E/M services or codes only cover evaluation and management. They basically involve examination and talking. If you perform anything other than examination or talking, there can be a separate code for it. For example, an ear exam is part of the physical examination and, hence, part of normal E/M service, but removal of impacted cerumen is not. There is a separate code for impacted cerumen removal; if you perform one, report it separately.

Non-E/M services a hospitalist may report may vary depending on the hospitalist's expertise and comfort level. Hospitalists typically have consulting physicians perform many procedures for them and end up not performing many procedures, but they may still perform procedures such as LP, difficult IV placement, central line placement, intubation, g-tube replacement, and cauterization of a granuloma. It is strongly recommended that physicians scroll through the pages of a CPT code book, find relevant codes for their practice, and use them to generate more revenue. You will be surprised by how many procedures you are already performing that are separately reportable. Chapter 4 provides useful information on common non-E/M service codes that pediatricians may use.

8-APPROPRIATE DOCUMENTATION OF SELECTED CPT CODE

The importance of documentation cannot be overemphasized, as reimbursement doesn’t depend on delivered care but rather on documentation. If a reported CPT code (or a claim) is not supported with appropriate documentation, then the claim may be denied. Please refer to section 6 for guidelines on appropriate documentation.

So, do not just select the highest level of code; also, document in your note that the patient actually qualifies for that level. If you are billing 99233, then either document high-level MDM or 50 minutes of total time.

9- APPROPIATE USE OF ICD CODES

CPT codes are always reported with ICD codes. ICD codes tell the payer about the reason for service, while CPT codes tell the payer about the nature of the service. You should align your CPT codes with ICD codes. If you report a high-level code, then you should list sicker-looking ICD codes, unless time-based billing is used. For example, if the sicket ICD code listed is URI, it may be difficult to justify code 99223, and the claim may be denied; however, it will likely be reimbursed if severe RAD exacerbation is used.

Reported ICD codes should reflect the patient's active problems being addressed, not inactive problems that are not addressed at that encounter. Chronic problems that are not contributing to medical decision-making are not relevant in selecting the level of MDM. Although ICD for unaddressed chronic problems may be listed, they are not as important as the acute problems. If you are reporting higher-level codes, then list the appropriate sick ICD codes first, before ICD codes of other unaddressed chronic problems.

10- DO NOT FORGET TO BILL

Physicians frequently lose revenue when they forget to bill. It's a good idea to have a system that reminds you to bill for every patient that you see. This can be a computer-generated or handwritten patient list, with a check mark for every patient who is seen and billed. If you are a teaching physician, it's a good idea to write down the list of the patients you have seen that day so that if a resident forgets to write a note, you can still detect the missing note and bill for it. If you do not have your own list, then you may not realize when a resident forgets to place a note, especially if you are signing your notes and billing days after being on service.

11- FOLLOW YOUR CLAIMS

Follow your claims (CPT codes) closely to ensure they are submitted appropriately and that denials are addressed. If you do not have a system in place to track your claims, you would have no idea how much revenue you are losing.

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CHAPTER 10 - HOW TO MAXIMIZE REVENUE GENERATION IN THE ICU?

A review of previous chapters, especially Chapters 3 and 4, is strongly recommended before reading this chapter, as it lays the foundations for optimal billing and documentation. Maximizing revenue generation is an important consideration for both private practice and academic physicians. There are many ways you can maximize revenue generation. We would take a detailed look at each one.

1- TARGET CRITICAL CARE CODES FIRST

Revenue from critical care codes is much higher than from non-critical care codes. Because of this, always aim for critical care codes first. If a patient meets the definition of critical care codes, you should not bill hospital admission, subsequent, or consultation codes unless you spend less than 30 minutes. Always look for a reason for critical care, like acute respiratory failure, hypoxemia, or hypotension. If a patient develops hypotension and you give a fluid bolus, then you have it; it is quite likely that this patient will qualify for critical illness and hence a critical care code.

The definition of time for critical care differs slightly from that for the rest of the E/M service codes. To deliver critical care, you should be immediately available to the patient. The practical result of this requirement is that when you are off the patient's floor, you cannot deliver critical care. If you are a hospitalist, you can count 30 minutes spent in the radiology department looking at MRI results with a radiologist, but the same thing does not count toward critical care time because you are not immediately available to the patient unless radiology happens to be next door to the ICU or you look at the MRI with the radiologist in the ICU. Another difference is that daily updates or times spent with caregivers do not count toward critical care unless these discussions influence the evaluation and management. Apart from these 2 exceptions, everything you do for a patient counts toward critical care time, as long as you are immediately available to the patient.

If the patient qualifies for pediatric or neonatal critical care codes, always bill these day-based critical care codes instead of the time-based codes, as their RVUs are higher. One golden rule for reporting pediatric/neonatal critical care codes is that these codes are reserved for the primary physicians who are keeping the patient under their care for the rest of that date/day. If you are not the primary attending or not keeping the patient under your care for the rest of the day, then you can't bill neonatal/pediatric critical care codes.

2- LIBERAL USE OF TIME-BASED CODE OF 99292

For patients billed with 99291 and 99292, as long as you are immediately available to the patient, almost everything you do for the patient counts toward time, and you should report the extra time with 99292. This is especially true for night coverage. For example, if a patient was billed by the day team with 99291/99292 and you provided care at night, you should consider billing 99292, provided the care meets the definition of critical care and the care time exceeds 15 minutes. There should be some form of intervention/management to qualify for this billing. You cannot just come at night time, round on

patients and bill 99292. If a critically ill patient worsens or develops an acute problem, and you spent 15 minutes or more, then this should be enough to bill 99292.

CPT and Medicare have different rules for billing 99292. According to CPT, it's possible to bill the first block of 99292 when half of its time (15 minutes) is spent after 60 minutes, meaning it can be billed at 75 minutes (60 + 15 = 75). According to Medicare, though, full 30 minutes of 99292 must be spent and counted after 74 minutes, meaning it can be billed after 104 minutes (74 + 30 =104 minutes)

According to CPT, physicians in the same group function as one; for this reason, it would be ideal for the first physician to document 60 minutes while reporting 99291; otherwise, the second physician needs to look at the first physician's note.

For example, if the day intensivist reports 99291 and documents 60 minutes of time, the night intensivist may report 99292 if 15 minutes or more of additional critical care is delivered. If the day intensivist reports 99291 but only documents 45 minutes, then to report 99292, the night intensivist should spend 30 minutes, since 99292 starts at 75 minutes.

Documenting 99291 as 1 hour and the 99292 as 30-minute increments (1 hour, 1.5 hour, 2 hours, 2.5 hours, 3 hours, etc) makes things easier.

Time-based/adult critical care codes 99291 and 99292 should also be known and billed by a neonatal intensivist when the intensivist cares for a neonate for only part of the day and transfers the patient to another institution or another physician group. Example: you come in the morning to the NICU and spend 6 hours on a baby and transfer the baby out for ECMO consult, then you should bill 1 unit of 99291 and 10 units of 99292.

Although you may generate more revenue with 99292 when time-based critical care codes are used, if day-based or pediatric/neonatal critical care codes are reported, you cannot generate more revenue by spending more time with the patient, because these codes are not time-dependent but day/date-dependent. For example, when you bill 99472, whether you spent 1 hour or 6 hours with the patient is irrelevant; the reimbursement is the same regardless of the time spent.

3- FOR NEONATES: TARGET NEONATAL INTENSIVE CARE CODES NEXT

Critical care codes can only be reported for critically ill patients. The neonatal intensive care code set exists for neonates/infants who are not critically ill but still require intensive monitoring and care. These codes have higher RVU than regular hospital/floor care codes (99221-99223 and 99231-99233) and should be used to generate more revenue when a baby requires frequent/intense monitoring and care. Like pediatric/neonatal critical care codes, these are day/date-based codes, and spending more time with the patient does not generate more revenue.

Neonatal intensive care codes are not restricted to neonatal ICUs and can be reported by pediatric intensivists in the PICU and by hospitalists caring for babies in the nursery or on the floor, as long as intense monitoring and care are provided, regardless of where they are provided.

Example: A 10-day-old neonate was admitted to the PICU, initially critically ill. After 3 days, the patient improved and is no longer critically ill, but still requires intense monitoring of vitals, exam, breathing,

temperature, and blood sugars. For this patient, instead of reporting hospital subsequent-day care codes (99231-99233), consider reporting neonatal intensive care codes 99478, 99479, and 99490.

4- FOR NON-CRITICAL PATIENTS AIM FOR THE HIGEST LEVEL HOSPITAL CODE

If the patient's condition does not meet the definition of critical illness (and not a newborn), then you are left with non-critical care hospital and consultation codes. The highest-level hospital codes (level 3) are 99223, 99233, and 99236. Outpatient consult codes, which are used in the ER and inpatient consult codes, have the highest level of 5. As explained in Chapter 2, there are 2 ways to reach the highest level. The first one uses total time, and the second uses MDM. You should always look at how much total time you have spent first. If you have spent enough time to meet the requirement for the highest level in a code set, then you should not bother looking at MDM, because, irrespective of MDM, you can report the highest level of code. If the total time you spend with the patient is insufficient for the highest level, check whether the MDM is sufficient to reach a higher level. This is the golden rule. Use the pathway that gives you the highest level. You may not turn level 1 into level 3 unless you spend enough time, but turning level 1 into level 2 or turning level 2 into level 3 may not be too difficult.

MDM-based E/M service codes for ICU use.

Code Set	**CPT code**	**Level**	**Time**	**MDM**
Admission	99221	Level 1	40 minutes	Straightforward/Low
	99222	Level 2	55 minutes	Moderate
	99223	Level3	**75 minutes**	High
Subsequent	99231	Level 1	25 minutes	Straightforward/Low
	99232	Level 2	35 minutes	Moderate
	99233	Level 3	**50 minutes**	High
Same day	99234	Level 1	45 minutes	Straightforward/Low
	99235	Level 2	70 minutes	Moderate
	99236	Level 3	**85 minutes**	High
Discharge	99238	N/A	<30 minutes	N/A
	99239	N/A	**>30 minutes**	N/A
Consult ER	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	Low
	99244	Level 4	40 minutes	Moderate
	99245	Level 5	**55 minutes**	High
Consult inpatient	99252	Level 2	35 minutes	Straightforward
	99253	Level 3	45 minutes	Low
	99254	Level 4	60 minutes	Moderate
	99255	Level 5	**80 minutes**	high

Almost everything that you do for patient care that is not reported with another CPT code is included in the total time. You do not need to be on the patient floor for the time to count.

1. Preparing to see the patient: **chart review, review of tests or imaging.**
2. Obtaining and/or reviewing separately obtained **history.**
3. Performing a medically appropriate **examination and/or evaluation.**
4. **Ordering** medications, tests, or procedures.
5. **Counseling** and educating the patient/family-caregive.r
6. **Referring and communicating** with other health care professionals.
7. **Coordination** of care.
8. **Documenting** clinical information in the electronic or other health record ~ **writing notes.**
9. Independently **interpreting results** and communicating results to the patient/family.

Example: the highest level in the hospital for a subsequent patient has 50 minutes of total time. If you spend 50 minutes on a subsequent patient, then you should bill level 3 (99233) irrespective of complexity/MDM. What if you spend only 35 minutes total time with a subsequent patient, which only qualifies for level 2 (99232)? Can you make it level 3 using MDM? If the answer is yes, *"based on MDM I can report level 3",* then report level 3 based on MDM. If MDM only qualifies level 1, then report level 2 based on total time.

Physicians tend to underestimate their time, but it is important to remember that everything you do for patient care counts toward the time, including writing your note. Time spent in pre-rounding, looking at vitals, labs, imaging, and notes; talking with consultants, radiologists, dietitians, or other team members; and time spent during rounds, including answering questions from patients or caregivers, all count toward time. Time spent on unrelated teaching during the rounds does not count. Time spent looking into textbooks, journal articles, online resources, drug doses, and side effects counts towards time as long as it's done to help with patient management. For example, you had a patient with AKI and looked up all the medications that the patient is on for their side effects on the kidneys. You have a patient with white matter lesions in the brain MRI, and looked in a textbook to determine what differential labs to send and how to manage this condition.

You can increase the total time spent on patient care by various means, including providing counseling or education, coordinating care, calling consultants, etc., as long as it is medically appropriate. For example, you have a patient with asthma exacerbation who is doing well and improving. If you spent only 25 minutes with this patient and the patient has low MDM, the patient only qualifies for level 1 (99231), but you can bill level 3 if you provide an additional 25 minutes of education on asthma prevention and management. 25+25=50 minutes = level 3, 99233. Another way to spend the extra 25 minutes with this patient may be to conduct management discussions with a pulmonologist and to plan follow-up care with a case manager.

Some E/M service codes are independent of time, like neonatal or pediatric critical care codes, neonatal intensive care codes, normal newborn care codes, and ED care codes. It does not matter how much time you spend when you report these codes. Discharge day care codes are divided into less than 30 minutes (99238) and more than 30 minutes (99239). When you spend more than 30 minutes, then it does not matter whether you spend 35 minutes or 3 hours for discharge.

We have seen above that by spending more time, you could increase the code level and hence revenue generation. Can a similar strategy work in the MDM pathway? The answer is yes, but instead of time, you should identify additional problems, data, or risks to increase the MDM level.

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Summary of targeting higher level in a code set

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	1 stable chronic illness < 2 stable chronic illnesses
	Stable chronic illnesses < chronic illness with exacerbation < chronic illness with severe exacerbation
	Acute, uncomplicated illness < acute illness with systemic symptoms < acute life-threatening illness
Data *Order and review more medically appropriate data elements*	Have independent historian
	Order and review more tests, *medically appropriate*
	Review external notes
	Provide independent interpretation of tests or imaging
	Management discussions with other providers
Risks	Prescription drug management *(giving or renewing prescription)*
	Diagnosis or treatment significantly limited by social determinants of health
	Drug therapy requiring intensive monitoring for toxicity
	Decision regarding hospitalization or escalation of hospital-level care
	Decision not to resuscitate or to deescalate care because of poor prognosis
	Parenteral controlled substances

5- USE PROLONGED CARE CODES

Prolonged care codes are not used for critically ill patients. For time-based critical care codes, the first hour of critical care is reported with 99291, and the remaining care is reported with multiple units of 99292. For day-based or pediatric/neonatal critical care codes, all care is included in the daily code, so whether you spend 1 hour or 10 hours with the patient makes no difference. Prolonged care codes are also not used with neonatal intensive care codes or discharge care codes, because these are day-based codes that encompass all care on that day/date.

Prolonged care codes may be used when non-critical care hospital codes are used. Please refer to Chapter 3 for details on prolonged care codes. There are basically 2 different types of prolonged care codes. Code 99418 is for a 15-minute care block used when you saw a patient and spent too much time with them on the same day/date. Second code group 99358 and 993569 is to report extra time for the patient care on the day/date that you have not seen the patient.

This code (99418) exists so you can bill for care beyond the typical. Examples include spending several hours with a socially difficult or medically complex patient, trying to figure out what is wrong, talking with multiple consultants or spending a lot of time at the bedside.

99358 is for the first hour, and 99359 is for each additional 30 minutes. It would be rare for an intensivist not to see their patient that day. These codes can be used in rare situations when you are involved in the care of a patient while not on service. An intensivist who takes calls at home may use these codes more commonly. For example, you were called by your resident at 9pm about a new admission, spent 30 minutes on the phone that night, and saw the patient the next day. Then you can report your time with these prolonged care codes for the night that you did not see the patient.

Prolonged care codes may be used by the night intensivist when they are on call and provide care to non-critically ill patients who become active at night. This may be an important source of revenue generation. 99418 involves 15 minutes of care. Most interactions with an active patient at night take at least 15 minutes, which is good enough for 99418. If you send 60 minutes, then you can report 4 units of 99418 (4 x 15 = 60). To report 99418 at night, though billing in the day should be either time-based 99223 or time-based 99233.

6-CONSULTS, RAPID RESPONSES AND CODE BLUES

You should report an E/M service code for any patient you see, including those for whom you are not the attending of record. This includes official consults on the floor, in the ED, or elsewhere, as well as non-official consults such as rapid responses or code blues. The reported code depends on whether you will stay as a consultant or take the patient as a primary physician. If you stay on as a consultant, initial consultation codes can be used for non-critical patients, and time-based critical care codes can be used for critically ill patients. You cannot report day-based pediatric/neonatal critical care codes while being on consult.

How to bill for rapid response and code blue elsewhere in the hospital depends on several factors. These patients are typically critically ill, and critical care codes may be reported. If the patient needs time-based critical care billing, then you should report your time in code or rapid response with 99291 and 99292. If you admit the patient to the ICU as the primary, you can bill day-based pediatric/neonatal

critical care codes for patients under 6 years of age. For these patients, you will not be able to bill for time spent in rapid response or code blue, as all the care you provided that day is reported using pediatric/neonatal critical care codes. If the rapid response patient is not critically ill, consultation, admission, or subsequent care codes can be billed, depending on the circumstances.

There are many instances in which a consultant spends a lot of time on the phone for patient care but does not physically see the patient that day. In this instance, you can report your time spent on that day with prolonged care codes 99358 and 99359, as long as you or your colleague in the same practice sees the patient in the following days or has seen the patient in the past. This can happen especially when you are on call at home.

7- MEDICAL TEAM CONFERENCE

Please refer to Chapter 3 for details on the medical team conference (team meeting). For team meetings, when the caregiver or the patient is present, the intensivist may report their time in the team meeting with time-based critical care codes if time-based critical care codes are used and the intensivist is immediately available to the patient. Day-based or pediatric critical care codes cover the entire care over 24 hours, so time in the team meeting is included in these codes and not separately reported. If the patient is not critically ill, time spent in the team meeting may be reported with an appropriate hospital care code, such as 99233, and prolonged care codes if needed. When the patient or caregiver is not present at the meeting, 99367 is used to report time, regardless of the type of billing code used.

8-KEEP OTHER RELEVANT E/M SERVICE CODES IN MIND

Advance care planning services with 99497-99498 (not reported with critical care codes)
Delivery room attendance and resuscitation services with 99464-99465
Telemedicine services.

9- DO NOT MISS PROCEDURAL OR NON-E/M SERVICE CODES

E/M services only cover evaluation and management. They basically involve examination and talking. If you perform anything other than examination or talking, there can be a separate code for it. For example, ear examination is part of physical examination, and hence part of normal E/M service, but removal of impacted cerumen is not. There is a separate code for impacted cerumen removal. If you perform impacted cerumen removal, report it separately with code 69210. Another example would be cauterizing a granuloma around a g-tube site. CPT code for cauterization of granuloma is 17250. If you did not know it, then you would lose the revenue.

The fact that there is code for the procedure that you have done does not necessarily mean that you can bill for that procedure. Whether you may or may not report a procedural code separately depends on the E/M service code that is billed for that day. This is because some E/M codes have bundles that include various CPT codes or procedures.

Apart from the bundle, both CPT and payers may have guidelines on what is separately reportable. For example, although not in critical care bundles, advanced care codes are not reported when critical care codes are used, and ventilator codes are not reported with any E/M service codes. Please refer to Chapter 5, NCCI edits for more information.

Non-bundled E/M service codes: non-critical and non-intensive care patients

Non-critical or non-intensive service care codes, such as hospital codes, consult codes, and discharge day care codes, do not have a bundle. Because there is no bundle, any procedure can be billed separately with these codes, except for NCCI edits or special payer policies.

Example: you placed a difficult PIV on a 4-month-old patient whom you have billed 99232 earlier. You can bill this procedure separately with CPT code 36406: *Venipuncture, younger than 3 years, not for routine, requiring physician's skill; other vein.* Although CPT code 34406 is included in the day-based bundle 99472, it does not apply to the non-critical care code 99232.

Bundled E/M service codes: critical and intensive care patients

Bundle of time-based critical care codes, 99291-99292: include 19 CPT codes

Bundle of day-based neonatal/pediatric critical care codes: 99468-99476: include 39 CPT codes

Bundle of neonatal intensive care codes: 99478-99480: include the same 39 CPT codes as above

Critically ill pediatric/neonatal transport codes: 99466, 99467: include 20 CPT codes.

Day-based bundles include all 19 CPT codes from the time-based critical care bundle, plus an additional 20 codes, for a total of 39. Example: arterial puncture (36600) is in both bundles, but arterial catheterization (36620) is only in the day-based bundles. Frequently performed procedures that are bundled in pediatric/neonatal critical care codes but not in time-based codes include: intubation (31500), CVL placement under 5 years of age (36555), arterial line placement (36620), LP (62270), and surfactant administration (94610). These codes are not billed separately when day-based critical care codes are used.

Below are the tables of CPT codes included in the time-based and day-based critical codes. Codes are color-coded for visual simplicity, with 19 codes in both time- and day-based bundles marked in black, and an additional 20 code in the day-based bundle marked in blue. CPT codes are written with a – sign between the numbers to make them easier to read (not in the original CPT code).

TIME-BASED BUNDLE: 99291 and 99292: 19 CPT codes	
36-000	Introduction of needle or intracatheter, vein
36-410	Venipuncture, age 3 years or older, not for routine, requiring physician's skill
36-415	Collection of venous blood by venipuncture
36-591	Collection of blood specimen from a completely implantable venous access device
36-600	Arterial puncture, withdrawal of blood for diagnosis
43-752	Naso- or Oro- gastric tube placement, requiring physician's skill and fluoroscopic guidance
43-753	Gastric intubation and aspiration therapeutic, requiring physician's skill, including lavage (eg for GI bleed)

71-045	Radiologic examination, chest, single view
71-046	Radiologic examination, chest ,2 views
92-953	Temporary transcutaneous pacing
93-598	Cardiac output measurements *(dilution methods, during cardiac catheterization for congenital heart defect)*
94-002	Ventilation assist and management, initial day
94-003	Ventilation assist and management , subsequent day
94-004	Ventilation assist and management, nursing facility, per day
94-660	CPAP initiation and management
94-662	Continuous negative pressure ventilation, initiation and management
94-760	Noninvasive pulse oximetry for oxygen saturation, single determination
94-761	Noninvasive pulse oximetry for oxygen saturation, multiple determination
94-762	Noninvasive pulse oximetry for oxygen saturation, by continuous overnight monitoring
Other	Blood gases, collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data)

DAY-BASED BUNDLE: 99468-99480: 39 CPT CODES	
31-500	Intubation, endotracheal, emergency procedure
36-000	Introduction of needle or intracatheter, vein
36-140	Introduction of needle or intracatheter, upper or lower extremity artery
36-400	Venipuncture, younger than 3 years, not for routine, requiring physician's skill; femoral or jugular vein
36-405	Venipuncture, younger than 3 years, not for routine, requiring physician's skill; scalp vein
36-406	Venipuncture, younger than 3 years, not for routine, requiring physician's skill; other vein
36-410	Venipuncture, age 3 years or older, not for routine, requiring physician's skill
36-415	Collection of venous blood by venipuncture
36-420	Venipuncture, cut down, younger than age 1 year
36-430	Transfusion, blood or blood components
36-440	Push transfusion, blood, 2 years or younger
36-510	Catheterization of umbilical vein for diagnosis or therapy, newborn
36-555	Insertion of non-tunneled centrally inserted central venous catheter, younger than 5years of age
36-591	Collection of blood specimen from a completely implantable venous access device
36-600	Arterial puncture, withdrawal of blood for diagnosis
36-620	Arterial catheterization or cannulation for sampling, monitoring or transfusion, percutaneous
36-660	Catheterization, umbilical artery, newborn, for diagnosis or therapy
43-752	Naso- or oro- gastric tube placement, requiring physician's skill and fluoroscopic guidance
43-753	Gastric intubation and aspiration therapeutic, requiring physician's skill, including lavage (eg for GI bleed)
51-100	Aspiration of bladder; by needle
51-701	Insertion of non-indwelling bladder catheter *(eg, straight catheterization)*
51-702	Insertion of temporary indwelling bladder catheter; simple *(eg, foley)*
62-270	Spinal puncture, lumbar diagnostic
71-045	Radiologic examination, chest, single view
71-046	Radiologic examination, chest, 2 views
92-953	Temporary transcutaneous pacing
93-598	Cardiac output measurements *(dilution methods, during cardiac catheterization for congenital heart defect)*

94-002	Ventilation assist and management, initial day
94-003	Ventilation assist and management , subsequent day
94-004	Ventilation assist and management, nursing facility, per day
94-375	Respiratory flow volume loop *(bedside pulmonary function test)*
94-610	Intrapulmonary surfactant administration by a physician through endotracheal tube
94-660	CPAP initiation and management
94-662	Continuous negative pressure ventilation, initiation and management
94-760	Noninvasive pulse oximetry for oxygen saturation, single determination
94-761	Noninvasive pulse oximetry for oxygen saturation, multiple determination
94-762	Noninvasive pulse oximetry for oxygen saturation, by continuous overnight monitoring
94-780	Car seat/bed testing
94-781	Car seat/bed testing, additional 30 minutes
No code	Blood gases, collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data)
No code	Monitoring or interpretation of blood gases
No code	Invasive or non-invasive electronic monitoring of vital signs

There are many procedures that are not in both bundles, including sedation and anesthesia codes, central line placement above 5 years, PICC lines, ECMO codes, bronchoscopy, IO, therapeutic LP, CPR, cardioversion, and the list goes on. These codes can be billed for any critically ill patients. Please look at chapter 4: non-E/M service codes for further information on these codes and a list of frequently used codes. I highly recommend screening the CPT code book to identify procedures you can bill separately. Chapter 4 only contains a limited number of separately reportable procedures.

Practical application

You performed a procedure, but are not sure whether it is separately reportable. How would you know?

1- Find out the CPT code number of the procedure you performed.

2- Decide which critical care code you will report for that day. **(NOT JUST AGE!)**

3- Find the correct bundle list associated with the critical care code.

- When you report 99291-99292, look at the 19-item time-based bundle list.
- When you report 99468-99469; 99471-99472; 99475-99480, look at the 39-item day-based bundle list.

4- Look at the bundle to see if the CPT code you performed is included in the list or not.

5-Finally, if the CPT code you performed is not in the list, then the procedure you performed is separately reportable. If it is included in the list, then you cannot separately report this procedure.

Complex circumstances

A good example is the placement of central lines (CPT codes 36555 and 36556). Universally, we think that it's bundled in the pediatric critical care codes and do not report these line placements separately when a pediatric critical care code is used. Now imagine that you are caring for a 5.5-year-old patient whom you billed 99476. If you place a central line, you will not report it because we all know that central lines are bundled in pediatric codes, but a closer look at the bundle suggests otherwise. The day-based or neonatal/pediatric critical care bundle includes only CPT code 36555, not 36556. Code 36555 applies to those age less than 5 years, and code 36556 applies to those aged 5 and above. Because this patient is above 5 years of age, the correct code is 36556. Since this code is not in the bundle, the

central line can be reported separately with the critical care code 99476. Central lines can be reported separately with day-based codes for patients older than 5 years of age.

This illustrates the importance of the age limit of different CPT codes. Pediatric critical care codes apply until 72 months, and time-based critical care codes start with age 6 years/72 months. Non-tunneled central line placement cut-off is 5 years/60 months.

Another good example, imagine that you did an LP on a 2-year-old critically ill patient and removed CSF for therapeutic reasons, you could be tempted to say that ''well LP is bundled in, I can't report it separately'' but if you take a closer look, you will notice that therapeutic LP has different CPT code of 62272 than diagnostic LP that is not in the bundle list. Although diagnostic LP cannot be reported separately for this patient, therapeutic LP can be reported separately.

The importance of the exact critical care code that is billed is highlighted in the next example. Imagine you intubated a 6-month-old patient and placed a central line, but due to the absence of room or other reasons, you transferred the patient to a different institution. In this example, you might be tempted to say, "*because of the age, I would not be able to bill for intubation and central line*" but that is wrong. Whether you can bill a procedure is not determined by the patient's age, but rather by the CPT code billed and its bundle list. The appropriate critical care codes for this patient are 99291-99292. Because you are transferring the patient out, you cannot use the day-based codes. Since you will bill 99291-99292, intubation and central line placement are separately billable because they are not in the bundle list.

10 - APPROPRIATE DOCUMENTATION OF SELECTED CPT CODE

The importance of documentation cannot be overemphasized, as reimbursement depends on documentation rather than delivered care. If a reported CPT code (or a claim) is not supported with appropriate documentation, then the claim may be denied. Please refer to Chapter 7 for guidelines on appropriate documentation.

So do not just select the highest level of code; also document in your note that the patient actually qualifies for that level. If you are billing 99233, then either document high-level MDM or 50 minutes of total time.

For critically ill patients, you should document that the patient's condition meets the CPT definition of critical illness or injury. CPT defines critical illness or injury as *"A critical illness or injury acutely impairs one or more of vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition*". Based on this definition, an intensivist should document impairment or failure of one vital organ and a high probability of deterioration. Otherwise, the patient may not be considered critically ill by the payers.

Another important documentation requirement for critical care notes is that CPT defines critical illness as high-level MDM. If critical care codes are reported, the note should also document high-level MDM.

Words that are used in the note are vital in the processing of claims, and they can mean the difference between acceptance and denial. In the past, critical care was defined as an unstable patient; hence, stable implied non-critical illness. This definition was changed, but it is still a good idea to limit the use of

the word stable. When stable is used, make sure you document that, despite being stable, the patient is still critically ill.

11- APPROPIATE USE OF ICD CODES

CPT codes are always reported with ICD codes. ICD codes tell the payer about the reason for service, while CPT codes tell the payer about the nature of the service. You should align your CPT codes with ICD codes. If you report high-level codes, then you should list sicker-looking ICD codes, unless time-based billing is used. For example, if the sickest ICD code listed is URI, it may be difficult to justify code 99223, and the claim may be denied; however, it will likely be reimbursed if severe RAD exacerbation is used. If critical care codes are reported, then the listed ICD code should be a critical illness. For example, there is probably no better ICD code than acute respiratory failure or shock for critical care billing, as it 100% percent implies critical illness and should always be listed first.

For critical care billing, a single ICD code for organ failure, such as acute respiratory failure, is sufficient. More ICD codes can be added, but they are not necessarily needed. Reported ICD codes should reflect the patient's active problems being addressed, not inactive problems that are not addressed at that encounter. Chronic problems, if not contributing to medical decision-making, are not relevant to selecting the level of MDM. Although ICD for unaddressed chronic problems may be listed, they are not as important as the acute problems. If you are reporting higher-level non-critical care codes, then list the appropriate sick ICD codes first, before inactive chronic problems.

12- DO NOT FORGET TO BILL

Physicians frequently lose revenue when they forget to bill. It's a good idea to have a system that reminds you to bill for every patient that you see. This can be a computer-generated or handwritten patient list, with a check mark for every patient who is seen and billed. If you are a teaching physician, it's a good idea to write down the list of the patients you have seen that day so that if a resident forgets to write a note, you can still detect the missing note and bill for it. If you do not have your own list, then you may not realize when a resident forgets to place a note, especially if you are signing your notes and billing days after being on service.

13- FOLLOW YOUR CLAIMS

Follow your claims (CPT codes) closely to ensure they are submitted appropriately and that denials are addressed. If you do not have a system in place to track your claims, you would have no idea how much revenue you are losing.

CHAPTER 11 - HOW TO MAXIMIZE REVENUE GENERATION IN THE NURSERY?

A review of previous chapters, especially chapters 3 and 4, is strongly recommended before reading this chapter, as it lays the foundations for optimal billing and documentation. Tips in chapter 9 may also be helpful when caring for sick babies. Maximizing revenue generation is an important consideration for both private practice and academic physicians.

Unfortunately, there are not many strategies to maximize revenue generation in the nursery. This is because most of the codes used in the nursery are non-MDM-based, and revenue generation is the same regardless of how much time is spent or how complex the patient is.

Table below shows the most commonly used codes in the nursey.

99460	***Initial** hospital or birthing center care, per day, for E/M of normal newborn infant*
99461	*Initial care, per day, for E/M of normal newborn infant seen in **other than hospital** or birthing center*
99462	***Subsequent** hospital care, per day, for E/M of normal newborn infant*
99463	*Initial hospital or birthing center care, per day, for E/M of normal newborn infant admitted and **discharged on the same date***
99238	*Hospital discharge day management, **30 minutes or less***
99239	*Hospital discharge day management, **more than 30 minutes***
99464	*Attendance to delivery (when requested by physician) and initial stabilization of newborn*
99465	*Delivery room resuscitation, provision of **positive pressure ventilation and/or chest compressions** in the presence of acute inadequate ventilation and/or cardiac output.*

For normal newborns, the initial day in the hospital is reported with 99460. The subsequent days are reported with 9462, and the discharge care day is reported with either 99238 or 99239. If the admission and discharge is on the same day/date, then 99463 is reported. Patient complexity or time spent has no effect on reimbursement rates when normal newborn codes are used.

1-NORMAL NEWBORN CODES ARE FOR NORMAL NEWBORN ONLY

Normal newborn codes are not used if the newborn is anything other than normal. Use appropriate E/M service codes for not-normal babies, including hospital, intensive, and critical care codes, when the newborn becomes sick. A good example is neonatal jaundice. Physiologic jaundice not requiring phototherapy is considered normal, and normal newborn codes are used; however, if the newborn requires phototherapy for neonatal jaundice, this is not considered normal and should be reported with sick hospital codes (99221-99223 and 99231-99233).

The same physician or members of the same group cannot bill a normal newborn care service with hospital admission code on the same day. For example, a newborn was seen in the morning, and 99460 was billed. Baby got sick and was admitted to the floor in the afternoon for IV antibiotics. Although a different physician group may use the hospital admission code 99223, the same physician or physician group may not bill this code on the same day; either should bill the normal newborn code or the hospital admission code for that day. The use of hospital codes is recommended, as they offer higher

reimbursement rates. Please review chapter 9 on how to best use the hospital code sets 99221-99223 and 99231-99233 to maximize revenue generation.

2- USE PROLONGED CARE CODES

Prolonged care code 99418 cannot be used with the normal newborn codes, but it can be used with hospital codes 99223 and 99233. Please refer to chapters 4 and 9 for more information on the use of prolonged care codes.

3- NEONATAL INTENSIVE CARE CODES ARE NOT RESERVED FOR NICU/NEONATOLOGIST

Neonatal intensive care codes may be reported by pediatricians working in the newborn nurseries as long as patients qualify for intensive care, irrespective of where the monitoring happens. Because of the intensive monitoring requirements, this care is delivered in the ICU setting at most hospitals. Intensive care is defined as services for infants or neonates who are not critically ill but continue to require

1- Intensive cardiac and respiratory monitoring.
2- Heat maintenance support.
3- Enteral and/or parenteral nutritional adjustments.
4- Laboratory and oxygen monitoring.
5- Constant observation by the health care team under the direct supervision of a physician.

If a monitored newborn condition meets the above criteria, neonatal intensive care codes may be reported and generate more revenue than relevant hospital codes.

4- NEONATAL CRITICAL CARE CODES

If a baby in the nursery becomes critically ill and is transferred to the NICU, the pediatrician caring for the baby may report time-based critical care services for initial stabilization prior to the NICU transfer. These services are reported with 99291 and 99292. Please refer to Chapter 10 for more information on using these codes to maximize revenue generation. For example, a normal newborn develops increased work of breathing, grunting with low sats in the 80s. The nursery pediatrician evaluates the newborn, obtains IV access, sends initial labs, obtains a CXR, places the patient on oxygen, orders antibiotics, spends 1 hour with the patient, and transfers the patient to the NICU. For this patient, the nursery pediatrician may and should bill the time-based critical care code of 99291.

5- MEDICAL TEAM CONFERENCE

Please refer to Chapter 4 for details on the medical team conference (team meeting). Reporting the time spent in the team meeting depends on the type of E/M code used when caregivers are present in the meeting. If normal newborn codes are used, the time in the team meeting is included in the daily normal newborn code and may not be billed separately. If the newborn is sick and a hospital code is used, time spent in the meeting may be counted toward the total time for that code, and prolonged care codes

may be reported if necessary. When a family member or caregiver is not present, then code 99367 can be used to report the time.

6- NON-E/M SERVICE CODES OR PROCEDURES

There are probably not many procedures done in the newborn nursery, but separate procedures like circumcision and car seat testing may be reported in addition to the newborn codes. Please review Chapter 5 for additional procedures that may be billed in the newborn nursery.

7- DO NOT FORGET TO BILL

Physicians frequently lose revenue when they forget to bill. It's a good idea to have a system that reminds you to bill for every patient that you see. This can be a computer-generated or handwritten patient list, with a check mark for every patient who is seen and billed. If you are a teaching physician, it's a good idea to write down the list of the patients you have seen that day so that if a resident forgets to write a note, you can still detect the missing note and bill for it. If you do not have your own list, then you may not realize when a resident forgets to place a note, especially if you are signing your notes and billing days after being on service.

8- FOLLOW YOUR CLAIMS

Follow your claims (CPT codes) closely to ensure they are submitted appropriately and that denials are addressed. If you do not have a system in place to track your claims, you would have no idea how much revenue you are losing.

CHAPTER 12 - FRAUD PREVENTION

Most physicians report their services honestly. Some physicians may report fraudulent claims that trigger system-wide audits. You should avoid any clinical activity that may be interpreted as fraudulent. Fraud is defined as "*obtaining something of value through intentional misrepresentation or concealment of material facts*". Intentionality is the core feature of the fraud. Things can happen by mistake, and if that is the case, there should not be a pattern of the same mistake happening again and again. A consistent pattern of mistakes, although can be explained by poor billing knowledge, can also be considered as a potential fraud.

Billing for services that are not actually delivered is the most important fraud category. One can consider 2 different categories of billing for services that are not delivered. The first category is billing for non-existent services.

Examples: A physician's 1 pm appointment is 6 months old, WCC. Patient had no show but physician still billed 99491 for WCC. Another physician sees a patient in the office with cellulitis and prescribes antibiotics, but in addition to the E/M service code, such as 99213, the physician also documents and reports the CPT code for incision and drainage that was not actually performed. These cases can be considered as fraud.

The second category involves billing for services that are higher than actually delivered. This is also known as overbilling. There are 2 types of overbilling in MDM based codes, the first one is MDM based overbilling, and the second is time based overbilling.

Example of an MDM-based overbilling. A physician sees a patient with a simple URI, documents it with no delivered care time, yet bills the highest level of code, such as 99215. This may be considered fraud because this patient does not qualify for level 5 based on MDM.

Example of time-based overbilling: A physician sees an established patient in the office and spends only 10 minutes with the patient, but documents 40 minutes in the chart and bills time-based 99215. Although proving overbilling in this case may be very difficult, it is still fraud. Although proving Individual overbilling may be difficult, proving time-based overbilling in a larger sample of patients may be quite easy. Imagine the same physician has a clinic that opens from 7am to 5pm, for 10 hours (600 minutes). During this time, he can only bill for 15 time-based 99215s, because each time-based 99215 is 40 minutes, and 15×40=600 minutes=10 hours. If the same physician bills 20 patients with time-based 99215, then 20×40 = 800 minutes, which is clearly beyond the time the clinic is open. Based on simple math, there may be a potential for fraud.

On the floor, if a hospitalist bills 30 patients with 99233 on the same day, this is also consistent with fraud, as 30 X 50 minutes = 1500 minutes, which is more than 1440 minutes in 24 hours.

A similar situation may happen on the hospital floor or in ICUs. One intensivist can provide critical care to only one patient at a time. This means that an intensivist can bill for only 24 hours of critical care using time-based critical care codes 99291 and 99292. For example, if an intensivist bills 99291 for 30 patients in a day and documents 1 hour per patient, this is clearly fraud, because 30 x 1 hour equals 30 hours, and there are no 30 hours in a 24-hour period. The minimum time required for 99291 is 30 minutes, and based on this, an intensivist may report a maximum of 48 units of 99291 (48 patients × 0.5 hour = 24 hours). If an intensivist bills 50 units of 99291 a day/date, then this is clearly a potential fraud.

CHAPTER 13 - REFERENCE CODE TABLES

Most commonly used office, outpatient E/M service codes

New Patient	-	99202	99203	99204	99205
Established Patient	99211	99212	99213	99214	99215
Consult - Office	-	99242	99243	99244	99245

Preventative Care/WCC – New Patient	99381	99382	99383	99384
Preventative Care/WCC – Established Patient	99391	99392	99393	99394

Most commonly used inpatient E/M service codes by Hospitalist

Initial admission	99221	99222	99223
Subsequent day	99231	99232	99233
Same day adm/discharge	99234	99235	99236

Consult ER	99242	99243	99244	99245
Consult Inpatient/Observation	99252	99253	99254	99255

Discharge day care < 30 min	99238
Discharge day care > 30 min	99239

Most commonly used inpatient E/M service codes by nursey pediatricians

Normal Newborn	Admission day	99460	
	Subsequent day	99462	
	Discharge day	99238	99239
	Same day adm/discharge	99263	

Delivery Room	Attendance to delivery	99464
	Resuscitation	99465

Most commonly used inpatient E/M service codes by Intensivist

Critical care codes –Time based/Adult		99291	99292
Critical care codes – Day based/Neonatal		99468	99469
Critical care codes – Day based/Pediatric	Age: 1mo -24 mo	99471	99472
	Age: 2yrs -6 yrs	99475	99476

Neonatal intensive care codes	Initial	99477		
	Subsequent	99478	99479	99480

Initial admission	99221	99222	99223
Subsequent day	99231	99232	99233
Same day adm/discharge	99234	99235	99236

Consult ER	99242	99243	99244	99245
Consult Inpatient/Observation	99252	99253	99254	99255

Discharge day care < 30 min	99238
Discharge day care > 30 min	99239

Office MDM-based code selection: MDM and Time levels

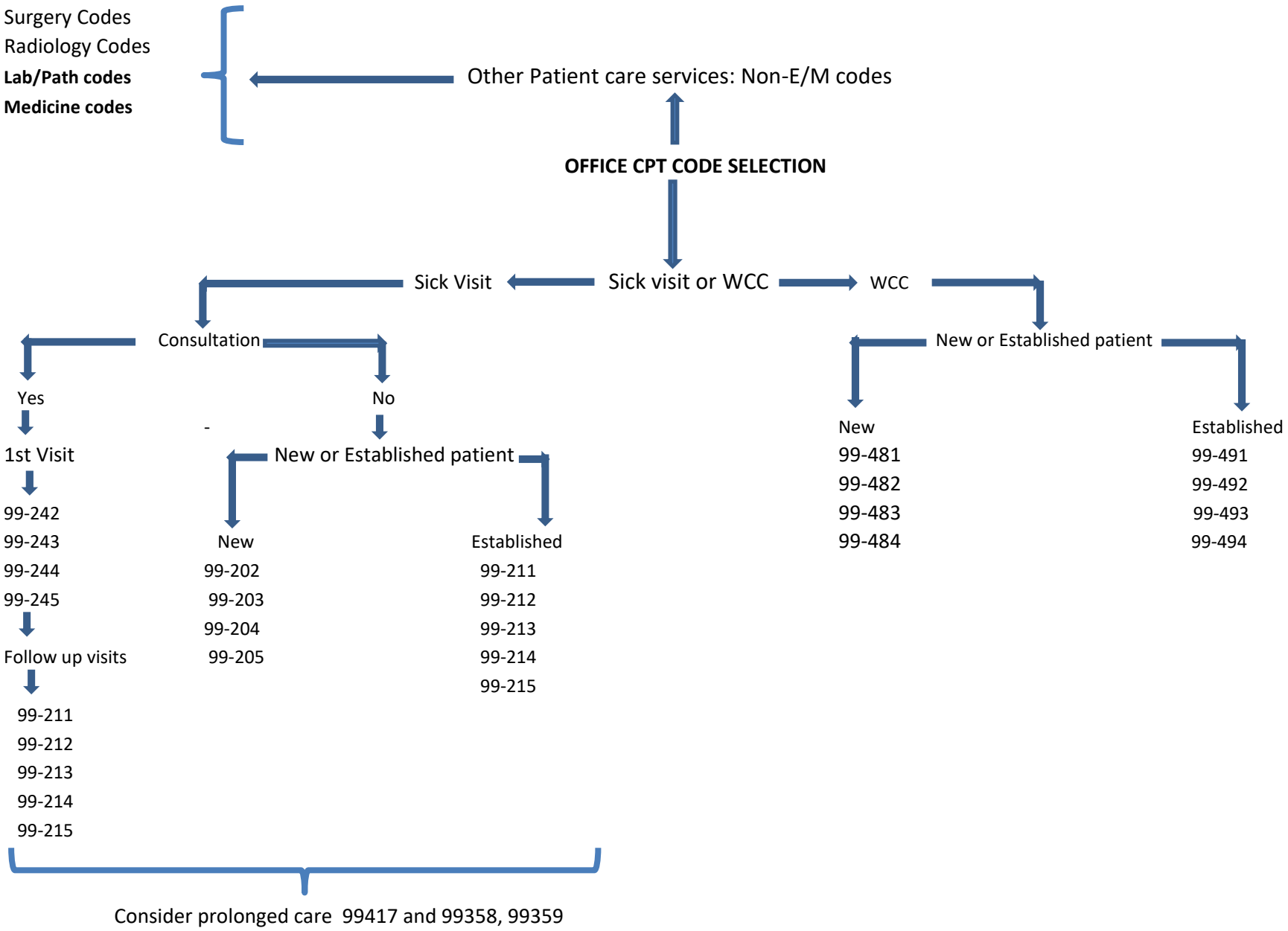
Code Set	CPT code	Code level	Time	MDM level
Office New Patient	99202	Level 2	15 minutes	Straightforward
	99203	Level 3	30 minutes	Low
	99204	Level 4	45 minutes	Moderate
	99205	Level 5	60 minutes	High
Office Established	99212	Level 2	10 minutes	Straightforward
	99213	Level 3	20 minutes	Low
	99214	Level 4	30 minutes	Moderate
	99215	Level 5	40 minutes	High
Consult	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	Low
	99244	Level 4	40 minutes	Moderate
	99245	Level 5	55 minutes	High

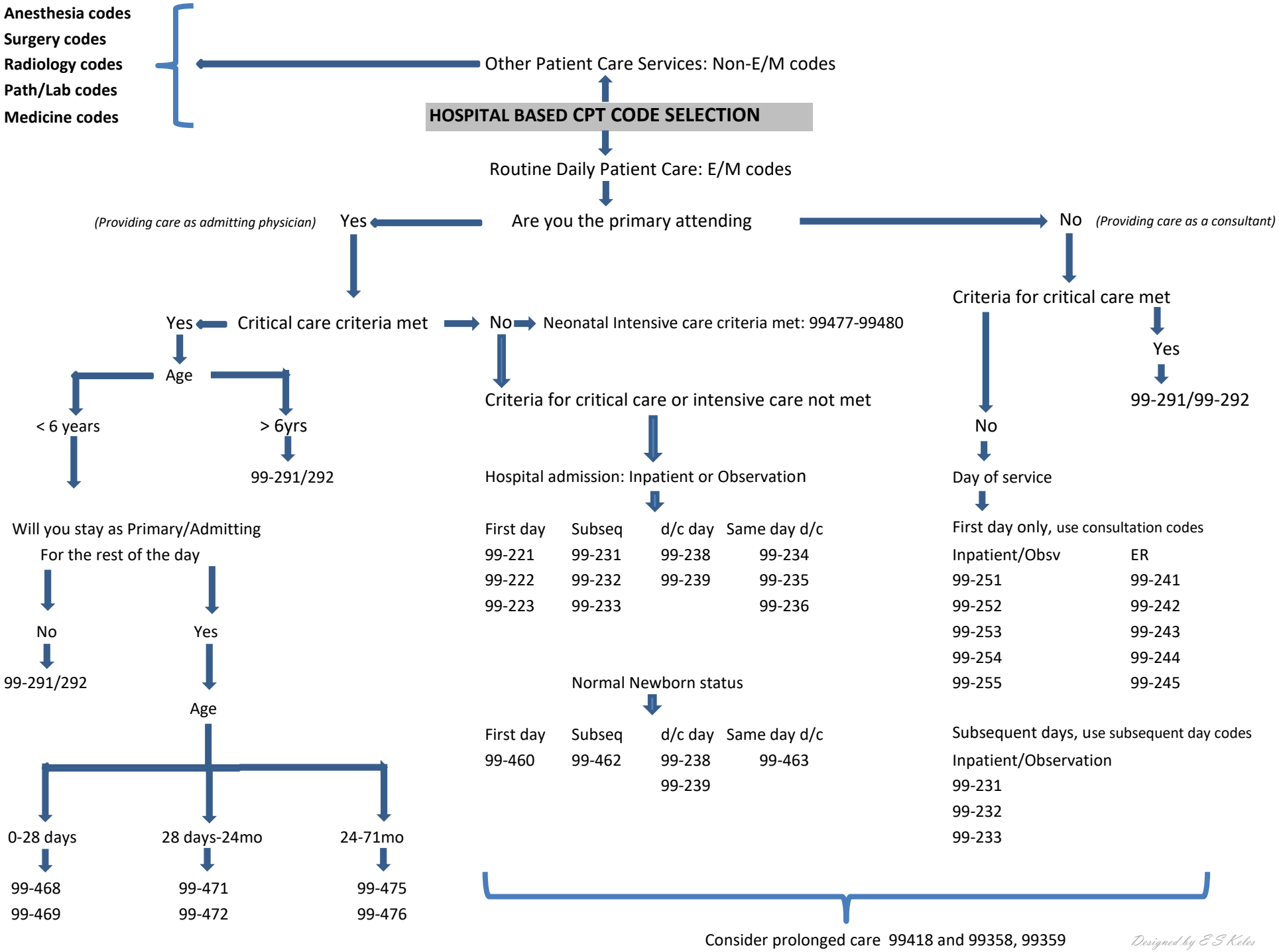
Hospital MDM-based code selection: MDM and Time levels

Code Set	CPT code	Code Level	Time	MDM
Admission	99221	Level 1	40 minutes	Straightforward/Low
	99222	Level 2	55 minutes	Moderate
	99223	Level3	75 minutes	High
Subsequent	99231	Level 1	25 minutes	Straightforward/Low
	99232	Level 2	35 minutes	Moderate
	99233	Level 3	50 minutes	High
Same day	99234	Level 1	45 minutes	Straightforward/Low
	99235	Level 2	70 minutes	Moderate
	99236	Level 3	85 minutes	High
Discharge	99238	N/A	<30 minutes	N/A
	99239	N/A	>30 minutes	N/A
Consult ER	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	Low
	99244	Level 4	40 minutes	Moderate
	99245	Level 5	55 minutes	High
Consult inpatient	99252	Level 2	35 minutes	Straightforward
	99253	Level 3	45 minutes	Low
	99254	Level 4	60 minutes	Moderate
	99255	Level 5	80 minutes	high

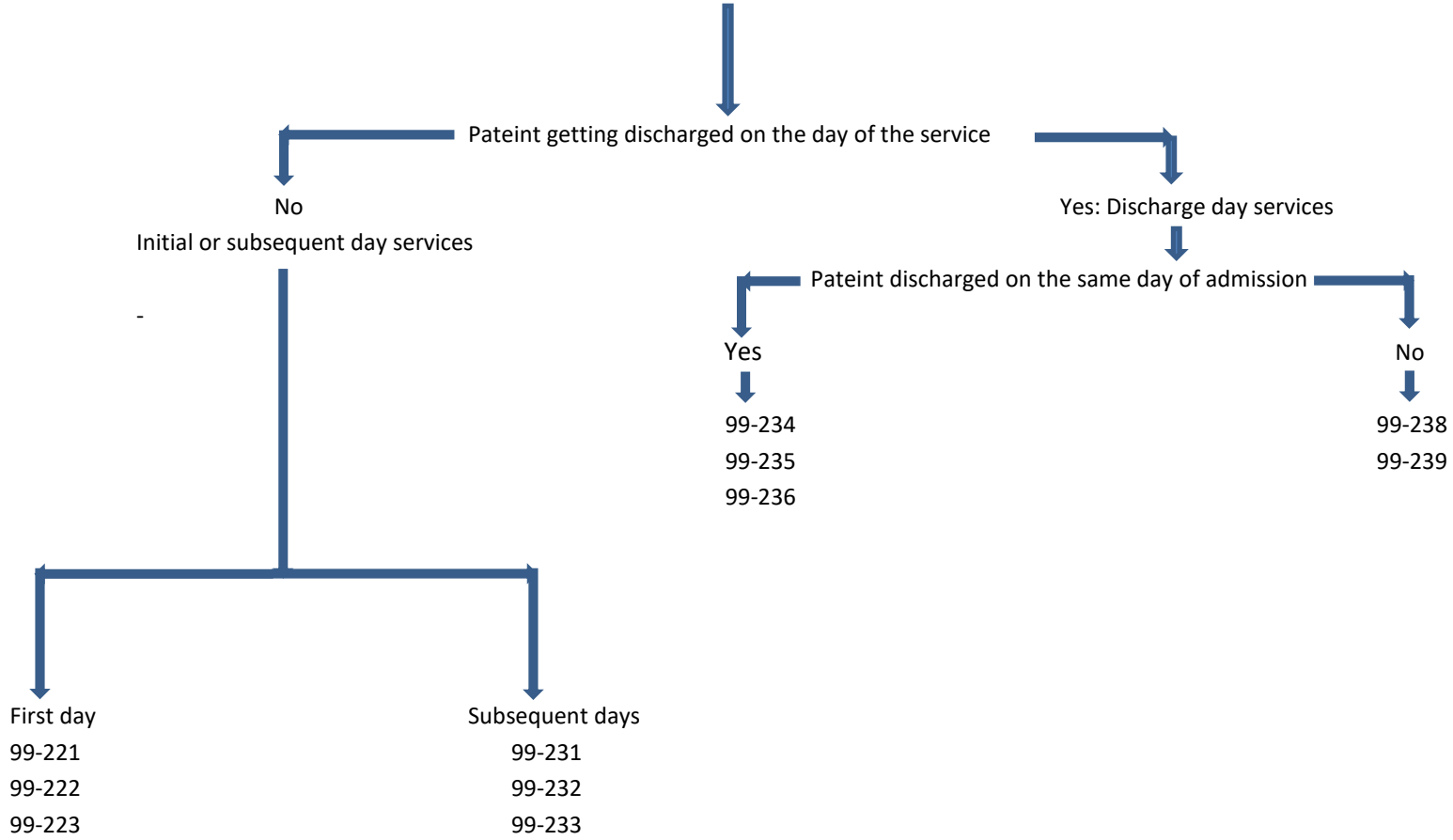
Non-MDM-Based code selection

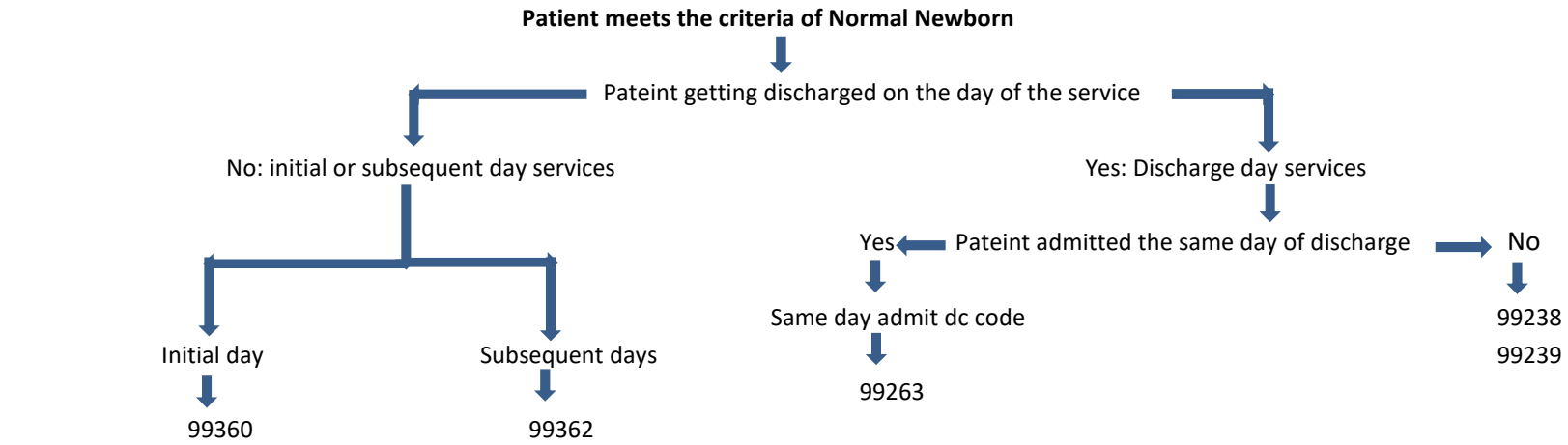
Well child check Preventative care	New Patient	<1 year			99481
		1-4 years			99482
		5-11 years			99483
		12-18 years			99484
	Established patient	<1 year			99491
		1-4 years			99492
		5-11 years			99493
		12-18 years			99494
Critical Care	Adult critical care codes		1st hour		99291
			each additional 30 minutes		99292
	Neonatal critical care codes		1st day		99468
			Subsequent days		99469
	Pediatric critical care codes		1 - 24 months	1st day	99471
				Subsequent	99472
			2-5 years	1st day	99475
				Subsequent	99476
Discharge care	Total care <30 min	99238			
	Total care >30 min	99239			
Normal Newborn care	1st day, hospital, or birthing center				9460
	1st day, other than hospital or birthing center				99461
	Subsequent hospital care				99462
	Admitted and discharged on the same date				99463
Neonatal Intensive Care	1st day	99477			
	Subsequent days	present body weight weight < 1500 grams			99478
		present body weight of 1500-2500 grams			99479
		present body weight of 2501-5000 grams			99480




Anesthesia codes
Surgery codes
Radiology codes
Path/Lab codes
Medicine codes
Other Patient Care Services: Non-E/M codes
HOSPITAL BASED CPT CODE SELECTION
Routine Daily Patient Care: E/M codes
(Providing care as admitting physician)
Yes
Are you the primary attending
No
(Providing care as a consultant)
Yes
Critical care criteria met
No
Neonatal Intensive care criteria met: 99477-99480
Age
< 6 years
> 6yrs
99-291/292
Will you stay as Primary/Admitting
For the rest of the day
No
99-291/292
Yes
Age
0-28 days
28 days-24mo
24-71mo
99-468
99-469
99-471
99-472
99-475
99-476
Criteria for critical care or intensive care not met
Hospital admission: Inpatient or Observation
First day Subseq d/c day Same day d/c
99-221 99-231 99-238 99-234
99-222 99-232 99-239 99-235
99-223 99-233 99-236
Normal Newborn status
First day Subseq d/c day Same day d/c
99-460 99-462 99-238 99-463
99-239
Criteria for critical care met
Yes
99-291/99-292
No
Day of service
First day only, use consultation codes
Inpatient/Obsv ER
99-251 99-241
99-252 99-242
99-253 99-243
99-254 99-244
99-255 99-245
Subsequent days, use subsequent day codes
Inpatient/Observation
99-231
99-232
99-233
Consider prolonged care 99418 and 99358, 99359
Designed by E S Keles

Hospital: inpatient or observation- not critically ill, not a normal newborn or requiring intensive care





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