Top Ten Underutilized CPT Codes in Pediatrics

1. 99214 and 99215 (established patient office or other outpatient services) represent only 20% and 5%, respectively, of all evaluation and management codes submitted in pediatric claims. If you meet the requirements set forth by CPT and have the appropriate documentation, you should bill for what you do, even if that is a fourth or fifth level visit.

2. 99241, 99242, 99243, 99244, and 99245 (office or other outpatient consultations) are underutilized in pediatrics. Did you know that these codes would be appropriate to use for a pre-op visit? Just make sure that you follow-up with the requesting physician (ie, the surgeon) with a written report. Many times, this requirement can be fulfilled with the completion of a hospital’s standard pre-op form.

3. Are you using the modifier 25 when a patient presents with a significant, separate problem or illness that is found during the course of a preventive medicine service visit? If you perform two significant, separately identifiable evaluation and management services during the course of a single visit, you should attach the modifier 25 to the office or other outpatient service code and list that in addition to the preventive medicine service code. Make sure to keep your office notes separate (either on a separate sheet of paper or separated by a line on a single sheet of paper) and to link the appropriate ICD-9-CM code (diagnosis) to each visit. For example, the preventive medicine service may be linked to V20.2 (routine infant or child health check), while the office or other outpatient service may be linked to 380. (acute swimmers’ ear).

4. Certain traumas may require you to perform evaluation and management, as well as additional procedures. Are you getting credit for your work? An example is when a patient presents as a victim of suspected child abuse. You are required to perform a complete evaluation and management service in addition to an anogenital exam with colposcopic magnification (99170). Therefore, you should report both the evaluation and management service and the colposcopy, making sure that you append the modifier 25 to the evaluation and management code to “red-flag” the fact that you performed a significant, separately identifiable evaluation and management service in addition to the colposcopy during a single visit.

5. What if a patient is rushed to your office with severe trauma? Do you see that patient right away, essentially on a “walk-in” basis and make all other patients wait? If you do, you should be billing for “service(s) provided on an emergency basis in the office, which disrupts other scheduled office services” (99058) in addition to the evaluation and management code.

6. What if a patient comes to your office after your regularly scheduled office hours? You should make sure that you are billing for 99050 (services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed) in addition to the evaluation and management code.

7. Do you have regularly scheduled office hours for Sundays? Did you know that you can charge for it? 99051 (service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service) can be reported in addition to the evaluation and management code.
8. Nursemaid’s elbow is a common occurrence in the pediatric population. Do you know that you can code for the treatment of it? Additionally, code 24640 (closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation) may be reported in addition to an evaluation and management code if a significant, separately identifiable evaluation and management service is provided. If this is the case attach the modifier 57 (decision for surgery) or the modifier 25 (significant, separately identifiable E/M service) to the associated evaluation and management code. Furthermore, you should note that Medicare assigns code 24640 a 10-day global period. This means that if a patient returns for follow-up within 10 days of the initial visit and their carrier follows Medicare global periods, you should not charge them for the portion of the visit that deals with the elbow re-check.

9. Do you have a patient who receives home health care? You can bill for care plan oversight! Care plan oversight codes (99339 and 99340) are reported separately from codes for office or other outpatient, hospital, home, nursing facility, or domiciliary services. 99339 (individual physician supervision of patient (patient not present) requiring complex and multidisciplinary case modalities involving regular physician development and/or revision to care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient’s care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes) and 99340 (30 minutes or more) should be billed once per month, based on the total amount of time spent on the aforementioned services. It might be a good idea to develop a permanent log sheet for the patient’s chart to keep track of the total time spent on the case; a few minutes here and there can really add up.

10. Do you spend a lot of time on the phone either talking to or discussing your patients? While the track record of payment for telephone triage/case management services is somewhat sketchy, it is still a good idea to bill for what you do. Physician case management is a process whereby a physician is responsible for direct care of a patient and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient. Whether you participate in a team conference call (99361; medical conference by a physician with interdisciplinary team of health professionals; approximately 30 minutes or 99362; approximately 60 minutes) or call the patient yourself (99371; telephone call by a physician to a patient; simple or brief, 99372; intermediate, or 99373; complex or lengthy), you are providing care for the patient and should bill for your services.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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