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Your Practical Guide to Current Coding

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Pediatric Intensive Care Services Codes

Critical care medicine is an essential and ever increasing component of health care provided across America. The high level of care, intensity of service(s), constant observation, and serious use of the illnesses and/or injuries associated with the critical care services codes make it essential that the coding population have an opportunity to evaluate and recommend changes to the critical care CPT codes. The guidelines for the critical care services and neonatal intensive care subsections of the evaluation and management (E/M) section of the CPT code set were revised for 2003 with added text

to reflect the revisions to the NICU-PICU code series and the addition of pediatric intensive care service codes. The new codes included:

- 99293 Initial pediatric critical care, 31 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child
- 99294 Subsequent pediatric critical care, 31 days up through 24 months of age, per day, for the evaluation and management of a critically ill infant or young child
- 99295 Initial neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 30 days of age or less
- 99296 Subsequent neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 30 days of age or less

These codes (99293-99296) are reported for services provided by a physician directing the care of a critically ill neonate/infant. The same definitions for critical care services apply to the adult, child, and neonate. Care rendered under 99293-99296 includes management, monitoring and treatment of the patient including respiratory, pharmacologic control of the circulatory system, enteral and parenteral nutritional metabolic and hematologic maintenance, parent/family counseling, case management services, and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

The pediatric and neonatal critical care codes include those previously listed procedures for the hourly critical care codes (99291, 99292). Additionally, the following procedures are also included in the bundled (global) pediatric and neonatal critical care service codes (99293-99296):

- Umbilical venous (36510) and umbilical arterial (36660) catheters
- Central (36488, 36490) or peripheral vessel catheterization (36000)

- Arterial catheters (36140, 36620)
- Oral or nasogastric tube placement (43752)
- Endotracheal intubation (31500)
- Lumbar puncture (62270)
- Suprapubic bladder aspiration (51000)
- Bladder catheterization (53670) (51701 or 51702)
- Initiation and management of mechanical ventilation (94656, 94657) or continuous positive airway pressure (CPAP) (94660)
- Surfactant administration, intravascular fluid administration (90780, 90781)
- Transfusion of blood components (36430, 36440)
- Vascular punctures (36420, 36600)
- Invasive or non-invasive electronic monitoring of vital signs, bedside pulmonary function testing (94375), and/or monitoring or interpretation of blood gases or oxygen saturation (94760-94762)

Any services performed that are not included in this list should be reported separately.

Neonatal Critical Care Codes

Codes 99295 and 99296 are used to report services provided by a physician directing the care of a critically ill neonate through the first 30 days of life. They represent care starting with the date of admission to the hospital (99295) and subsequent day(s) (99296) and may be reported only once per day, per patient. Once the neonate is no longer considered critically ill, the intensive (non-critical) low birth weight services codes should be used for those with a present body weight of less than 2500 g (99298 or 99299) or the codes for subsequent hospital care (99231-99233) for those with a present body weight greater than 2500 g.

Code 99295 is reserved for the date of admission for neonates who are critically ill. Critically ill neonates require cardiac and/or respiratory support (including ventilator or nasal continuous positive airway pressure [CPAP] when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas

interpretations, follow-up physician re-evaluations, and constant observation by the health care team under direct physician supervision. Immediate preoperative evaluation and stabilization of neonates with life threatening surgical or cardiac conditions are included under this code. It is important to note that care for neonates who require an intensive care setting but who are not critically ill is reported using the initial hospital care codes (99221-99223).

Code 99296 is reserved for each subsequent day(s) services provided by a physician directing the care of a critically ill neonate through the first 30 days of life. The critically ill neonate will continue to require cardiac and/or respiratory support (including ventilator or nasal CPAP when indicated), continuous or frequent vital sign monitoring, laboratory and blood gas interpretations, follow-up physician re-evaluations throughout a 24-hour period, and constant observation by the health care team under direct physician supervision.

It is important to note that while the neonatal critical care codes (99295-99296) bundle commonly performed services such as intubation, umbilical vein catheterization (UVC), and umbilical artery catheterization (UAC), it is appropriate to report such procedures separately when they are performed as a medically necessary part of a distinct E/M service associated with an infant resuscitation in the delivery room and even when reported on the same calendar day as a neonatal critical care code.

According to CPT guidelines, the neonatal critical care codes are not to be reported until the patient is "admitted to an intensive care unit" (*CPT 2003, Professional Edition*, page 21). During neonatal resuscitation or as part of airway suctioning for meconium, an endotracheal intubation may be medically indicated. Because delivery room care and management is considered "pre-admission," the medically necessary procedures performed during that period of service in the delivery room are not considered bundled into the neonatal critical care codes that commence only after the nursery admission, even if they are reported on the same calendar day.

Example

A neonatologist attends the delivery of a 1000-g infant who requires intubation for respiratory distress as well as placement of both arterial and venous umbilical catheters while still in the delivery room. Later that same day, the critically ill infant is admitted to the neonatal intensive care unit. How should these services be reported? From a CPT coding perspective, the services should be reported as follows:

- 99440** Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output
- 31500-59** Intubation, endotracheal, emergency procedure
- 36510-59** Catheterization of umbilical vein for diagnosis or therapy, newborn
- 36660-59** Catheterization, umbilical artery, newborn, for diagnosis or therapy
- 99295** Initial neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 30 days of age or less

Rationale

Code 99440 is reported when the delivering physician requests the presence of the neonatologist at the delivery and positive pressure ventilation and/or chest compressions are utilized as part of the resuscitation. If positive pressure ventilation is not needed, then code 99436, *Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn*, is reported. Either code includes initial drying, stimulation, suctioning, "blow by" oxygen, and a cursory visual inspection of the infant. Notation in the infant's chart documenting that the delivering physician requested the presence of a neonatologist as well as the indications for his/her presence should be recorded. Additionally, the medically necessary procedures performed while in the delivery room should be reported, including 31500 for intubation, 36510

for UVC, and 36660 for UAC. This holds true even if the infant is admitted to the NICU directly from the delivery room or later that day. Modifier '59,' *Distinct procedural service*, should be appended to codes 31500, 36510, and 36660 to indicate that those procedures are distinct from the neonatal critical care code, 99295.

In summary, the key points to reporting such procedures include the following:

- The procedure(s) must be performed in the delivery room before the patient is admitted.
- The procedure(s) must be performed as a necessary component of the resuscitation and not as a convenience before admission to the NICU or as a method of capturing further revenue.
- Lastly, the resuscitation note should document that the procedure was necessary to successfully resuscitate the infant.

Infant/Pediatric Critical Care Codes

Codes 99293-99294 are used to report services provided by a physician directing the care of a critically ill infant or young child after the 30th day of life up to 24 months of age. The pediatric critical care codes are reported as long as the infant/young child qualifies for critical care services during the hospital stay. They represent care starting with the date of admission (99293) and subsequent day(s) (99294) and may be reported by a single physician only once per day, per patient in a given setting. The critically ill or critically injured child older than 24 months when admitted to an intensive care unit would be reported with hourly critical care service codes (99291, 99292). As in the case of a neonate, once an infant is no longer considered to be critically ill but continues to require intensive care services, the intensive (non-critical) low birth weight services codes (99298, 99299) should be used to report services for infants with a present body weight of less than 2500 g. When the present body weight of those infants exceeds 2500 g, the subsequent hospital care (99231-99233) codes should be utilized.

In unique circumstances, it may be necessary to report two critical care services codes on the same date of service by two different physicians. Codes 99293-99296 represent each "full day's" service provided by the same physician for a single date, upon admission to the hospital and the inpatient course thereafter. For example, Physician A provides 90 minutes of critical care service to a patient who is 42 days old in an outpatient setting (eg, emergency department, office). Later that same date, the patient is admitted into an inpatient setting and Physician B provides the inpatient critical care for the remainder of that date. You may ask, should code 99293 be reported alone or are both codes 99291 and 99292 reported since 90 minutes of critical care were provided in the outpatient setting? In this situation, it is appropriate for Physician A to report codes 99291 and 99292 for the 90 minutes of critical care services provided in the outpatient setting. Physician B would then report code 99293 for the initial inpatient pediatric critical care for that same date. The new pediatric critical care codes (99293, 99294) and the revised neonatal critical care codes (99295, 99296) are reported for inpatient critical care services, for the respective age groups, on the date of admission and subsequent calendar days of the inpatient stay. Editorial revisions to the critical care instructions reflecting the site of service will be forthcoming in the CPT book.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that "the version of the medical data code sets specified in the implementation specifications must be the version that is valid at the time the health care is furnished." In order to provide the most accurate and compliant health information and health data reporting, it is of the utmost significance to allow for review and recognition of these new and revised CPT codes. The new code descriptors allow for unambiguous reporting of critical care and services provided to neonates and children. ■