List of suspected—but ruled out—pediatric conditions has grown.

1. Find New Codes for Suspected—But Ruled Out—Newborn Conditions

In some situations, the pediatrician will encounter a patient without a confirmed diagnosis, but he’ll suspect that the patient has an abnormal condition requiring further evaluation (or sometimes even testing). However, in some cases, the doctor may subsequently rule out the suspected condition after further investigation. If you’re flummoxed about how to code these situations, the new batch of ICD-10 codes have answers. You’ll find the following new codes, among others.

- Z05.0—Observation and evaluation of newborn for suspected cardiac condition ruled out
- Z05.1—Observation and evaluation of newborn for suspected infectious condition ruled out
- Z05.2—Observation and evaluation of newborn for suspected neurological condition ruled out
- Z05.3—Observation and evaluation of newborn for suspected respiratory condition ruled out
- Z05.41—Observation and evaluation of newborn for suspected genetic condition ruled out
- Z05.42—Observation and evaluation of newborn for suspected metabolic condition ruled out

This partial list represents several codes—but not all—from the new Z05 category. You’ll also find codes for suspected immunologic conditions (Z05.43), gastrointestinal conditions (Z05.5), genitourinary conditions (Z05.6), musculoskeletal condition (Z05.72) and more among the new ICD-10 codes for newborns. These codes are perfect to use when seeing a neonate at their three to four day-old post-hospital visit when a condition is suspected but ruled out. The first visit within three to five days of life often includes checking to see if the neonate is jaundiced (Z05.42), has a heart problem (Z05.0) or any of those listed above.

Keep in mind that the ICD-10-CM Official Guidelines for Coding and Reporting offer very specific guidelines for the use of codes in this category. “There are two observation Z code categories. They are for use in very limited circumstances when a person is being observed for a suspected condition that is ruled out,” the Guidelines advise. “The observation codes are not for use if an injury or illness or any signs or symptoms related to the suspected condition are present. In such cases the diagnosis/symptom code is used with the corresponding external cause code.”

2. Look for New ‘Light for Gestational Age’ Dx

In your existing ICD-10 manual, you’ve got several options available when the pediatrician sees a newborn who is of low weight based on their gestational age, ranging from “less than 500 grams” (P05.01x) through “2000-2499 grams” (P05.08x). Starting this October, however, you’ll also get additional options in this category, as follows:

- P05.09—Newborn light for gestational age, 2500 grams and over
- P05.19—Newborn small for gestational age, other

3. Find New CALME Code

Your ICD-10 manual currently includes a code that refers to hypertrophy of the vulva (N90.6), but some pediatricians require more specificity when treating pediatric patients with vulvar diagnoses. That led the CDC to debut the following two codes, which will go into effect on Oct. 1:

- N90.61—Childhood asymmetric labium majus enlargement (CALME)
• N90.69—Other specified hypertrophy of vulva

You’ll also find a new code for pre-pubertal vaginal bleeding (N93.1) that could be useful when treating pediatric patients who have this condition.


Pediatric Mythbuster: Yes, You Do Need to Follow Global Periods for Minor Procedures

Even if you don’t perform “surgeries,” you are subject to global surgical package rules.

Myth: Because pediatricians don’t perform surgeries and aren’t typically subject to Medicare regulations, they don’t need to follow global surgical periods when seeing patients.

Reality: Not only do minor procedures have some global periods associated with them, but even services that have “000” global days actually still fall under the global surgical package rules. Therefore, pediatric offices should be just as aware of the global surgical regulations as other specialists.

Consider This Example

A reader recently contacted Pediatric Coding Alert with this query: “We saw a child three times in the past week—on the first visit, the doctor did an incision and drainage (I&D) on an abscess and packed the wound. On the subsequent two visits, the pediatrician repacked the wound and the patient left. What do we report for the two repacking visits? Just an E/M code?”

The reality is that if you report an I&D code such as 10060 (Incision and drainage of abscess [e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia]; simple or single), then any E/M code you use for the next 10 days will be bundled into the initial I&D payment, because these codes have 10-day postoperative periods. This means unless the physician has to repeat the procedure, those visits are inclusive into the procedure.

On the other hand, if you have a visit for the I&D but the pediatrician finds other issues he needs to address with an E/M service, then you can report the E/M code linked to the other diagnosis code. You would append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the day of a procedure or other service) to the E/M code to demonstrate that it was separate and distinct from the I&D on the first visit.

On the second or any subsequent visit during the global period, if there are other issues found, bill the office visit with a 24 modifier (Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period) to indicate it is not inclusive in the global period. Without the use of the 24 modifier, the visit will bundle as global.

Don’t Be Surprised by Globals

The number of commonly-performed procedures linked to ten-day global periods may surprise you, and include the following, among others:

• 11200: Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
• 24640: Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation

Therefore, if you perform one of these procedures and you administer an E/M service within the next ten days that’s related to the procedure, your insurer will likely bundle the payment for the E/M service into the amount you received for the procedure.
If, however, you perform an E/M that’s not related to the procedure, you can use modifier 24 to separate it. For instance, if you performed an I&D for an abscess as in our example above, you probably used the diagnosis for an abscess when you submitted the charge for the surgery. If the patient presents for a repacking of the I&D and the pediatrician also evaluates the child’s acne, you can report the E/M code with modifier 24 linked to the acne code.

Know the Rules for '000' Day Globals

Some services have "000" global days assigned to them, and although you may think that "000" truly means “zero,” that’s not the case. The 000 classification means the procedure adheres to bundling rules only on the date of the service. Most payers will therefore bundle all services that you perform on the surgery date into codes with this 000 global period.

Commonly-performed procedures such as the following carry "000" global days:

- 54150: Circumcision, using clamp or other device with regional dorsal penile or ring block
- 12001: Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
- 69210: Removal impacted cerumen requiring instrumentation, unilateral

Therefore, if you perform an E/M service that prompts you to perform cerumen removal with instrumentation, the payer will bundle the associated E/M service on that date into the payment for the cerumen removal. If the procedure is not directly related to the visit (e.g., impacted ear wax with an otitis media diagnosis), then bill the E/M code with a 25 modifier to indicate it is a separate service not related to the impaction.

‘X’ Marks the Spot for These Procedures

The majority of procedures that pediatricians perform, such as vaccinations (e.g., 90460, Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered) carry a global period of “XXX.”

An XXX modifier means the service is truly free of global surgical bundling issues, meaning that unless Correct Coding Initiative (CCI) or payer-specific edits bar you from billing the procedure with an E/M code, you should be free to bill an E/M service with the procedure on the date of service.

Commonly-reported pediatric procedures with XXX global periods include the following, among others:

- 96372: Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
- 94010: Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

CMS notes that this code is payable “for claims with dates of service on or after Aug. 1, 2016, processed on or after Jan. 3, 2017,” according to MLN Matters article MM9793. Although most pediatric practices don’t bill Medicare for their services, many private payers follow Medicare’s lead, so this could be the case with your private payers as well. Always ask your insurers for details on when specific codes go into effect.

Scratch 99420 From Superbills

In addition to the vaccine changes, CPT® has also deleted 99420 (Administration and interpretation of health risk assessment instrument [eg, health hazard appraisal]). “This code has been used frequently by pediatric practices for our maternal depressions as well as some health risks like lead and concussion screening.

Instead, when you perform screenings, you have to select from among the following two new codes:

- 96160 — Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
• **96161** — *Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument*

As the descriptors indicate, these codes will more accurately indicate who the subject of the assessment is—the patient versus the caregiver. "It may also be easier to get paid for these two codes versus the 99420 when done with another E/M code. With the 99420 being an E/M code, many times it was paid and the visit itself was bundled into the payment for the 99420. It is unclear what type of RVUs will be assigned to the new codes, but keep an eye on Pediatric Coding Alert for more on these codes as payers release information about how to report them.

**Support Higher-Level Family Counseling Sessions Using 7 ‘Z’ Codes**

**This series helps show why $64 more for a 99214 could be in order.**

Still don't have Z62-Z63 series on your superbill? Your E/M levels could be suffering.

Pediatricians frequently deal with dysfunctional families, and the Z62 (*Problems related to upbringing*) and Z63 (*Other problems related to primary support group, including family circumstances*) groups can support work done within these codes’ described issues.

Using a counseling diagnosis often supports a higher level of CPT® coding for these time-dominated visits.

**Discover 7 Disruption Types**

Family visits can encompass a variety of situations, and many of them warrant a “Z” code to describe the circumstances. For instance, an encounter needed for a family member on military deployment would warrant reporting Z63.31 (*Absence of family member due to military deployment*). This could apply if the patient is having sudden issues with sleeping, OCD or other problems when her parent deploys. If, however, the family presents for a visit to discuss issues that have surfaced after the parent returned from deployment, Z63.71 (*Stress on family due to return of family member from military deployment*) would be more accurate.

Other codes include disruption due to the following circumstances:

- **Z63.5** - Disruption of family by separation and divorce
- **Z63.4** - Disappearance and death of family member
- **Z62.21** - Child in welfare custody
- **Z62.81** - Personal history of abuse in childhood (add a sixth digit to denote the type of abuse, such as Z62.812, *Personal history of neglect in childhood*)
- **Z63.8** - Other specified problems related to primary support group (includes issues such as “inadequate family support NOS,” “family estrangement,” “family discord” and more).

**Look for Counseling Session’s Condition, Percentage**

You’ll find significant potential for using the family disruption codes in counseling sessions regarding divorce, foster care, military parents, etc., and should apply these codes to describe to the insurer exactly why the visit was necessary.

What CPT® codes could you use for a family disruption counseling session? Typically, you’ll report an E/M code such as 99201-99215 for a family visit. Remember that the descriptor for these E/M codes says that the visits in this category can involve time “with the patient and/or family.”

Before reporting these services, consider these requirements:

- **E/M level:** If the counseling and/or coordination of care dominates (more than 50 percent) the physician/patient and/or family encounter (face-to-face in office or other outpatient settings), time can be the key or controlling factor to qualify for a particular level of E/M service, such as 99201-99215. Documentation must include the encounter’s total face-to-face
time, counseling time, and a brief discussion summary.

Example: A mother asks a pediatrician to talk to her daughter about an impending divorce and to discuss the custodial arrangements. The physician spends 10 minutes gathering the history of the divorce and asking questions about the patient’s health. He then spends 15 minutes counseling the parent and patient on her concerns, fears, and anger, and documents “spent 15 total minutes counseling on managing feelings during upcoming divorce and changed living arrangements. Total visit time is 25 minutes.”

Based on the performed and documented history, examination, and medical decision making, the visit qualifies as a level-two established-patient office visit (99212, Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making ... Physicians typically spend 10 minutes face-to-face with the patient and/or family).

However, because counseling comprised more than 50 percent of the encounter’s total face-to-face time, you instead can select the E/M level using time as the controlling factor, resulting in a claim for code 99214 (... a detailed history; a detailed examination; medical decision making of moderate complexity ... Typically, 25 minutes are spent face-to-face with the patient and/or family).

Reporting Z63.5 for this service helps support the visit’s higher level of 99214 which equates to approximately $64 more in pay than 99212, which you would have reported if you hadn’t billed based on time spent.

Recognize Other Z62 and Z63 Encounters

You’ll sell yourself short if you limit family disruption ICD-10 codes to counseling sessions. You might find Z62 and Z63 beneficial when a patient seeks or receives medical advice or care due to family disruption. If the physician uses an E/M code, there could be other diagnoses, such as stress (for instance, F43.0, Acute stress reaction) and/or depression (for example, F43.21, Adjustment disorder with depressed mood). “You might also want to look at the ‘Signs and Symptoms of an Emotional State’ series to see if any of those diagnosis codes apply as well. If so, use the specific code as primary and then the Z code as secondary.

Don’t miss: You’re free to couple the ‘Z’ codes with another ICD-10 code, as appropriate. For example, a teenager who is was recently removed from her home by child welfare officials has been experiencing fatigue and weight loss. During an office visit, the pediatrician diagnoses her with depression caused by her living situation. The physician assigns a level-four established-patient visit based on performed and documented key elements of history, examination, and medical decision making.

This type of visit could support 99215 (... a comprehensive history; a comprehensive examination; medical decision making of high complexity ... Physicians typically spend 40 minutes face-to-face with the patient and/or family) if the total visit is 40 minutes and total face-to-face time counseling on the diagnoses related to depression, child welfare removal from the home, and other diagnoses. For the diagnoses, you would submit fatigue (R53.83), weight loss (R63.4), depression (F32.9), and Z62.21.

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