

**Improving Early Childhood Health and  
Developmental Services  
Using EPSDT Policy:  
EPSDT Services and the Coding  
Conundrum**

**March 3, 2009**

**Speaker: Joel Bradley, M.D., Associate Medical Director,  
AmeriChoice by United Health Care**

This webcast will begin at 3pm Eastern

Please hold until Neva Kaye starts the conference

The audio portion of this webcast can be accessed by dialing  
866.740.1260

Access Code: 8223913

# OUR GOALS

- Improve the knowledge of correct coding for EPSDT services
- Understand how the correct use of existing coding systems can facilitate EPSDT data tracking and provide opportunities to reward providers for higher screening rates

# Your Presenter

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- AAP Representative to the AMA RBRVS Update Committee and former Member AMA CPT Panel
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# OUR PLAN

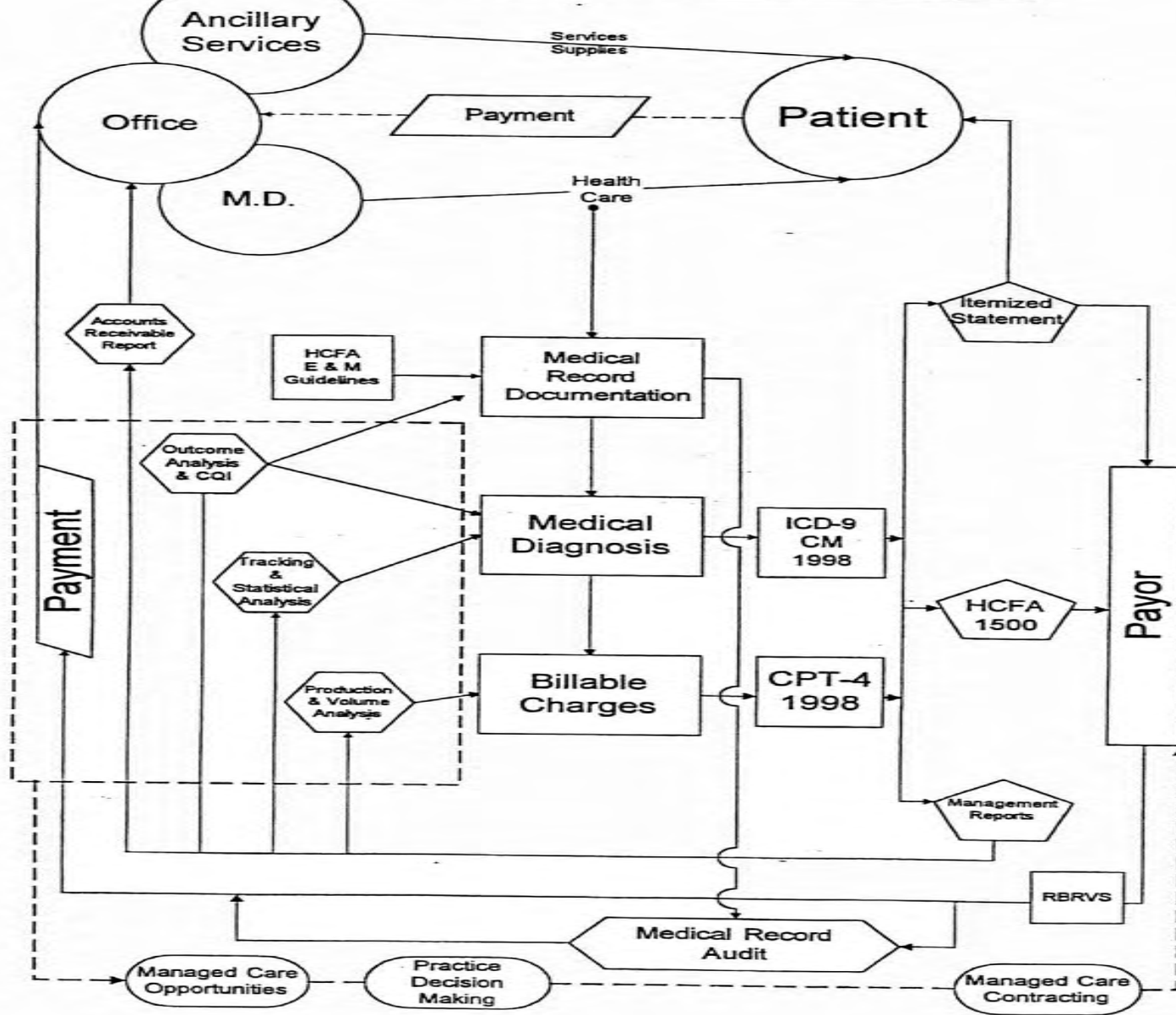
- Review how codes for services fit into the payment and tracking system for EPSDT services
- Discuss the Current and Correct CPT and ICD codes used for EPSDT services
- Learn some EPSDT system "best practices" that may improve EPSDT quality of service

# The Format

Questions are welcome-  
Answers also!

# Medical Encounter

"The Medical Encounter-Documentation, Coding, Reimbursement and Managed Care"  
(Submitting for Publication)  
Charles M. Vandiere, MD, FAAP



# EPSDT PHYSICIAN SERVICES

- OFFICE PREVENTIVE VISITS
- HOSPITAL WELL NEWBORN CARE
- SCREENING SERVICES and TESTS
- IMMUNIZATIONS

# First...How Physician Services Are Paid

# Terminology-"Physicians or Providers"?

Physicians , Advanced Practice Nurses, Physician Assistants can all provide and report EPSDT services if -

1. -their service meets their individual state licensure laws for scope of practice, and
2. -they are "credentialed for payment by a state Medicaid program or other Medicaid payer

For this seminar the terms will be used interchangeably

# Terminology-"Coding" or "Reporting" or "Billing" ?

Coding- Picking the Code to match the service

Billing-

The process of preparing and submitting the bill (charge) for a provider service to a payer

Reporting - A nice way of saying "bill"- used by CPT to mean submitting the code selected for payment or for tracking

All used interchangeably

# The Revenue Cycle

SERVICE ⇒ CODE

⇒ VALUE ⇒ RBRVS

⇒ FEE SCHEDULE

⇒ CONTRACT

⇒ PAYMENT

# The Coding System

The Coding System Is a  
Key Component of Quality  
Data Tracking and the  
Reimbursement for Physician  
Services

# The Coding System

Physicians Report Services Provided to Patients to Payers Using Numeric or Alphanumeric Codes

HIPAA Requires Certain Code Sets for Electronic Transactions

CPT and ICD are the Core Code Sets Used by All Physicians (and Payers)

# Healthcare Common Procedure Coding System (HCPCS)

## Two Levels

Level One- Current Procedural Terminology 4

Level Two- HCPCS Alphabetic codes

Level Three- Local Codes (sunset with HIPAA)

# Current Procedural Terminology (CPT 4)

- Copyrighted publication of the AMA
- Became by law the standard Medicare code set since 1990's
- Over 8000 Codes describe a wide variety of services

Updated twice a year in October-codes are active 1 Jan.

# Current Procedural Terminology (CPT 4)

- Updated twice a year in October-codes are active 1 Jan.
- Three Code Categories-
  - I- Mainstream codes for billing
  - II- Codes for Performance Improvement –used in pay for performance programs
  - III- Codes for New Technology

# Current Procedural Terminology (CPT-Cat I)

- Divided into sections based on general areas of medicine
  - Evaluation/Management
  - Anesthesiology
  - Surgery
  - Radiology
  - Pathology and Laboratory
  - Medicine

# CPT CODES-"What Physicians Do"

- E/M SERVICES
  - Evaluation and Management Services
  - Generally more "cognitive"
  - First section of CPT
- PROCEDURES
  - Rest of book
  - Surgery, Labs, X-rays etc

# HCPCS-Level II

- Code Categories by alpha- A through V
  - Codes are alphanumeric eg J0133Injection, acyclovir, 5 mg
  - Codes for DME, supplies, Dental, PT/OT/Drugs and others
- G Codes - Temporary Procedures/Professional Services (G0001-G9016) Established for Medicare

# HCPCS - S Codes - Temporary National Codes (Non-Medicare) (S0009-S9999)

- S0302 Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate Evaluation and Management service)
- S0310 Hospitalist services (list separately in addition to code for appropriate Evaluation and Management service)
- S0315 Disease management program; initial assessment and initiation of the program
- S0316 Disease management program, follow-up/reassessment

# HCPCS Level 2- S Codes

- S0302 Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate Evaluation and Management service)
- S0310 Hospitalist services (list separately in addition to code for appropriate Evaluation and Management service)
- S0315 Disease management program; initial assessment and initiation of the program
- S0316 Disease management program, follow-up/reassessment

# HCPCS Level 2

## T Codes - Codes Established for the State Medicaid Agencies (T1000-T2011)

Examples-

T1014 Telehealth transmission, per minute, professional services bill separately

S0320 Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month

T1005 Respite care services, up to 15 minutes

# International Classification of Disease (ICD)-9-CM

- Published by the World Health Organization for epidemiological tracking of illness and injury
- The clinical modification ( CM ) in the US is controlled by
  - CMS
  - National Center for Health Statistics/CDC
  - American Hospital Association
  - American Health Information Management Association

# DIAGNOSIS (ICD 9) CODES-"The Patient"

- ESTABLISH MEDICAL NECESSITY
- EACH CPT CODE IS LINKED TO 1 OR > DIAGNOSIS CODE(S)
- DESCRIBE
  - Patient, (not the service) or
  - Condition (Sign, Symptom, DX)
  - Reason for Encounter
  - Usually 5 digits

# DIAGNOSIS (ICD 9) CODES

- *Three Types*
  - Numeric Codes - problems, illness
  - V Codes- preventive care (EPSDT)
  - E Codes (secondary codes)

# HOW SERVICES ARE PAID

Next...Codes Find A VALUE  
(AMA RUC)

Then...CMS Publishes in the  
RBRVS or Medicare Fee  
Schedule)

# RBRVS AND PEDIATRICIANS

Resource Based Relative  
Value Scale

# RBRVS

- Fee Schedule of CMS-Medicare
- Used by most ALL Payers
- Most CPT codes have a "Relative Value" or "rvu" including the preventive medicine services
- 99381 - rvu/CMS \$ = 2.51/\$90.53

# RBRVS AND PEDIATRICIANS

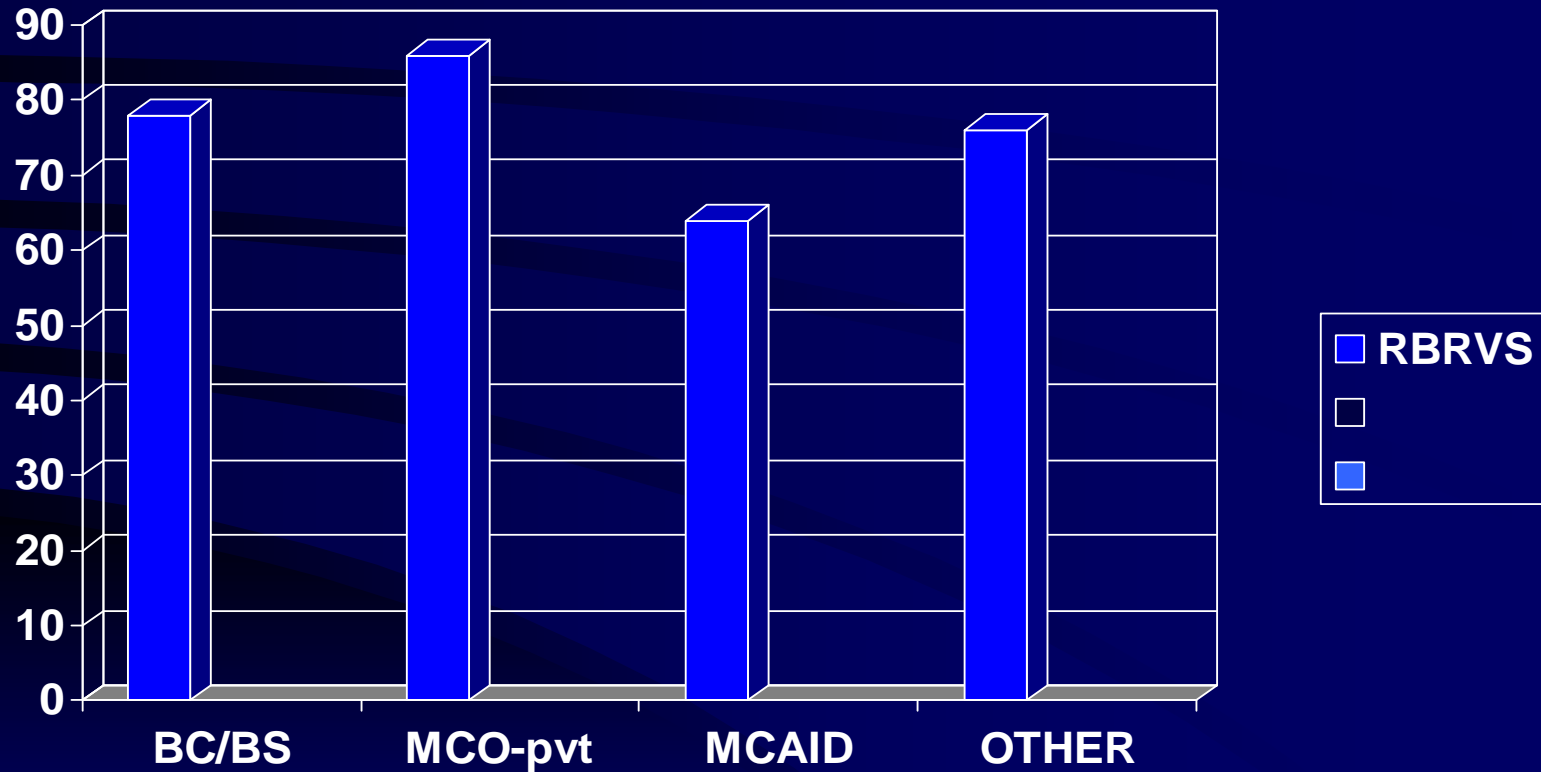
- RBRVS
- **CONCEPT** - Services are ranked relative to the costs of the resources used to perform them.
  - If service A is harder and takes longer, or uses more overhead expense of service B, then A will have a proportionately higher value than B.

# RBRVS- MAJOR COMPONENTS of an RVU

1. PHYSICIAN WORK
2. PRACTICE EXPENSE
3. MALPRACTICE EXPENSE

**\*\*the relative value of any CPT code is driven by the CPT description and reporting rules**

# RBRVS by PAYER TYPE



# The RBRVS

Most State Medicaid programs and Medicaid managed care companies use the RBRVS (Medicare Physician Fee Schedule) or parts of it as the basis for paying physician claims

# HOW SERVICES ARE PAID

Plus... Many PAYERS- Adopt RBRVS and CPT Coding Rules with variations and deviations-

"PAYMENT POLICY" for physicians who may participate in 20 or more plans"

# HOW SERVICES ARE PAID

## Benefits and Covered Services

There is variation on coverage from one health plan to another including state Medicaid programs

While the Medicare fee schedule has a complete set of values for EPSDT services- it does not itself cover Preventive Medicine Codes

# HOW SERVICES ARE PAID

Last.....PROVIDER  
CONTRACTS

With PAYERS

(Individual physician , Group  
Practice, IPA )

# EPSDT Service- The CPT Codes and Coding Rules

- Most services performed as part of an EPSDT exam have their own separate CPT codes, and their own relative values
- The relative value of the main Preventive Medicine code does not contain the relative value (payment) for those other services

# EPSDT Service- The CPT Codes and Coding Rules

- These services or components of the EPSDT ARE bundled into the relative value (payment ) for the Preventive Medicine Service-
  - History including developmental and Physical Examination
  - Anticipatory guidance and education of the patient/family

# EPSDT Service- The CPT Codes and Coding Rules

- These services or components of the EPSDT ARE Not bundled into the relative value (payment ) for the Preventive Medicine Service-
  - Screening Tests for vision, hearing, and development/behavior
  - Laboratory testing- Blood hemoglobin and lead, blood lipid, urine, STD, SBI service
  - Vaccines (vaccine administration)
  - Evaluation and management of significant other non-preventive problems (eg asthma)

# Preventive Medicine Services

- E/M services performed in the absence of a significant problem/abnormality
- Extent and focus depends on the patient's age
- Includes counseling/anticipatory guidance/risk factor reduction

# PREVENTIVE VISIT CODES

EASY TO SELECT CORRECT  
CODE

- BY AGE GROUP, AND
- NEW OR ESTABLISHED

# NEW PATIENT

a new patient is one who has received-

- ◆ no professional face to face services
- ◆ from the physician or a same specialty group partner
- ◆ or covering (call) physician
- ◆ in the past **three** years.

# Preventive Medicine Services

## New Patient

Initial E/M of a new patient requiring a comprehensive history, comprehensive exam, identification of risk factors, ordering of appropriate tests, and counseling

99381 Age < 1 year

99382 Ages 1 - 4 years

99383 Ages 5 - 11 years

99384 Ages 12 - 17 years

99385 Ages 18 - 39 years

# Preventive Medicine Services

## Established Patient

Periodic reevaluation and management requiring a comprehensive history, comprehensive exam, identification of risk factors, and ordering of studies

99391 Age < 1 year

99392 Ages 1 - 4 years

99393 Ages 5 - 11 years

99394 Ages 12 - 17 years

99395 Ages 18 - 39 years

# Preventive Medicine Services-CPT Coding Rules

- "Comprehensive Nature" not same as other E/M codes
- Code separately for - labs, immunizations, screening tests with their own codes! (EPSDT)
- Use -25 modifier for significant-separate abnormality

# Preventive Medicine Services-CPT Coding Rules

- "Comprehensive Nature" not same as other E/M codes
- "Extent and focus of services will largely depend on the patient's age"

# ICD or Diagnosis -V Codes - Preventive Services

- V 20.2- Use with CPT codes <18 yo
- V 70.0 - Use with CPT code >18 yo
- V 72.3 - Use for well woman exam >18 yo
  - Use with CPT preventive code for age
- V 70.3 -camp or sports physical
  
- \*link to the CPT code for the EPSDT service

# Preventive Medicine Services-CPT Coding Rules

- Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests (eg, vision, hearing, developmental) identified with a specific CPT code are reported separately. For immunization administration and vaccine risk/benefit counseling, see 90465-90474 and for products see 90476-90749

# Screening Services

- 92551 - hearing screen, pure tone only, both ears
- 96110 - developmental testing (DDST) w/report
- 99173 - visual acuity screening
  - may be reported w/ preventive care codes, but not if part of a general medical exam
  - Most states define the individual tests which are suitable for use- See AAP Bright Futures 2008 Preventive Health Schedule for guidelines

# Vision Screening

**99173**

Screening test of visual acuity, quantitative, bilateral (eg, Snellen chart)

- May be reported with preventive medicine services
- May not be reported with a general E/M service related to an eye or vision problem
- It is a screening test code

# Vision Screening New-Photostcreening

**99174**

Ocular photoscreening with  
interpretation and report, bilateral

# Hearing Screening

- **92551** - hearing screen, pure tone only, both ears
- **92586** - Auditory evoked potential for evoked response audiometry, limited test (screen)

# Central Nervous System Assessments/Tests (Developmental screening)

- **96110**
- -Developmental testing, limited, with interpretation and report
- Use as add-on code for EPSDT
- Example- PEDS, MCHAT, ASQ

# Immunizations and EPSDT

From birth to age 21 yrs there are  
50 vaccines now recommended

Essential that Medicaid programs  
work very closely with state  
vaccine programs to support  
systems that maintain the public  
health

# Immunizations-Vaccine for Children

All patients with Medicaid qualify for free vaccine from birth through age 18

Physicians report and are paid for the immunization administration only- CPT codes 90465-90474

Physicians will still need to report the CPT codes for the Vaccine products for tracking with a "\$0" charge

# Immunizations-Vaccine for Children

From age 19 up to age 21 recommended vaccines are covered EPSDT services but not VFC eligible- state programs will need to establish a fair vaccine product fee schedule

For all vaccines delivered the Immunization fee should fully support the delivery (ACCESS TO) of the service -the RBRVS for these CPT administration codes is the only resource based standard for establishing fees

# V Codes for Vaccines

Either V Codes usually work-vaccine specific codes are best

- If a well visit, can use Well Child or Vaccine specific ICD codes
- If not on a well visit, use vaccine specific V codes
- New for 2003-DTaP-IPV-HBV= 90723+V06.8 "other combination vaccine"

# EPSDT Coding Rules- Addressing Separate Medical Behavioral Problems

- If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. **Modifier 25** should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

# EPSDT Coding Rules- Addressing Separate Medical Behavioral Problems

- An **insignificant** or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service **should not** be reported.

# What is Significant?

- A separate visit would have been needed to diagnose and treat, or
- A prescription is required to diagnose and treat
- The work of the problem service must be documented in addition to the EPSDT service

# Service Modifiers

- Added to the E/M and/or procedure code(s), they tell the third party payer that additional work and/or services were provided



# Modifiers

Services altered by specific circumstance

\*Tells insurer "this visit is different"

Attach to end of code- 99213-25)

- 21 Prolonged E/M Service
- 22 Unusual Procedural Service
- 24 Unrelated E/M Service during global
- 25 Significant separately identifiable E/M Service by the same physician on the same day

# -25 Modifier

If a significant problem/abnormality is found at a preventive medicine visit:

- Document the specific issue separately
- Code the appropriate E/M visit in addition to 99381-99385 preventative medicine codes
- Add modifier -25 to the E/M code-99213-25
- REMEMBER correct CPT-ICD linkage
- Use to add procedure to an E/M service

# CODING EXAMPLE

FOUR MONTH FEMALE - WELL BABY VISIT. Sick also-

- Comprehensive history /pe/ screenings
- Also noted- otitis media,URI

- DX = 1. Growth and development wnl 2. URI / Otitis Media
- RX = 1. immunizations 2. Amoxicillen

# The Separate Medical Problem Physician Options

1. PERFORM BOTH WELL (EPSDT) AND SICK SERVICES AT THE SAME VISIT
2. PERFORM ONLY THE SICK VISIT, DEFER THE PREVENTIVE VISIT INCLUDING IMMUNIZATIONS TIL WELL (RESCHEDULE)
3. Which is a best clinical practice? Which is best for the Patient and the Program?

# CODING EXAMPLE- BILLING OPTIONS

- IF PERFORM BOTH WELL AND SICK SERVICES AT THE SAME VISIT
  - 1. Bill for both (-25 modifier)-99291 + 99213-25
- PERFORM THE SICK VISIT, DEFER THE PREVENTIVE VISIT INCLUDING IMMUNIZATIONS TIL WELL (RESCHEDULE)
  - 1 Bill for sick visit (E/M office visit) 99213

## Example: -25 Modifier

Est. patient visit for well baby visit- also sick with a cold: has ear infection on exam that is treated.

99291- Preventive Visit, age under 1 yr.  
link to ICD V20.2

99213-25 Level 3 E&M -for the illness  
link to ICD 464.5 and 382.00

# OFFICE VISITS- NON PREVENTIVE CARE

## General types of visits

- 99211- nurse visit
- 99212- easy, brief problems
- 99213- average, usual problems
- 99214- "oh no"
- 99215- post visit "just ran a marathon" feeling

# 99211

## TYPICAL PRESENTING PROBLEMS

1. Nurse visit (provides a service)

- Bp check

- Throat culture

- Neonate-weight check

- ADHD medication refill

DOCUMENT A SERVICE !

# 99212

## TYPICAL PRESENTING PROBLEMS

1. Diaper rash
2. OM recheck-resolved
3. Otitis Externa
4. Thrush

# 99213

## TYPICAL PRESENTING PROBLEMS

1. Fever and pharyngitis
2. UTI- cystitis
3. URI and Otitis
4. Influenza, uncomplicated
5. (most uncomplicated acute illness)

# 99214

## TYPICAL PRESENTING PROBLEMS

1. Chronic problems
2. Acute complicated illness
3. Abdominal pain, Headaches
4. Fatigue, anorexia
5. Fever without focus
6. School, behavioral problems
7. ADD -return visits

# 99215

## TYPICAL PRESENTING PROBLEMS

1. Diabetes complicated by influenza
2. Headaches with vomiting
3. Abdominal pain, disabling
4. Fatigue, anorexia in teen
5. Fever without focus - < 60 days
6. School, behavioral problems
7. ADD - initial evaluation

# E/M: Normal Newborn Care May Count as EPSDT

- 99460 - Normal newborn H&P admit and discharged on same day
- 99461 - Normal newborn H&P provided outside a hospital or birthing center

# Newborn- Hospital Discharge

- 99238 - 30 minutes or less
- 99239 - more than 30 minutes
- Includes discharge exam, discussion of stay, review of discharge plans and all discharge paperwork

# Questions?

# NASHP

- 20 year old non-profit, non-partisan organization
- Academy members
  - Peer-selected group of state health policy leaders
  - No dues—commitment to identify needs and guide work
- NASHP staff
  - Develop, identify, and disseminate promising practices
  - Work informed and guided by members
- Working together across states, branches and agencies to advance, accelerate and implement workable policy solutions that address major health issues

## Contact information:

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