Peer Reviewed

Add-On Codes in Neonatal Critical Care

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"Many neonatologists would recognize these common procedures, including thoracentesis, thoracostomy, partial exchange transfusion, exchange transfusion, abdominal paracentesis, peripherally inserted central catheter, subdural/reservoir or shunt tap, and circumcision, as procedures that are not included in the global intensive or critical care codes."

Several years ago, an article appeared in Neonatology Today titled "The Bunded Neonate," which focused on procedures that were either not bundled into the global Current Procedural Terminology (CPT®) intensive care and critical care codes or could be used in the setting of delivery room management or hourly critical care codes.[1] Many neonatologists would recognize these common procedures, including thoracentesis, thoracostomy, partial exchange transfusion, exchange transfusion, abdominal paracentesis, peripherally inserted central catheter, subdural/reservoir or shunt tap, and circumcision, as procedures that are not included in the global intensive or critical care codes.

Within neonatology, scenarios exist that require additional work and expertise. The daily global CPT® codes for critical care (99468, 99469, 99471, and 99472) account for the considerable work required by the physician in directing care. This work is measured using relative value units (R.V.U.s), encompassing physician work, practice expense, and malpractice. Physician work considers the time, skill, training, and intensity required for providing a service.

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The most common situational examples a neonatologist may face where the work surpasses the global daily critical care codes R.V.U.s are in extracorporeal life support/extracorporeal membrane oxygenation (ECLS/ECMO) and therapeutic hypothermia. In both instances, using the add-on codes and the daily global critical care code is appropriate. The R.V.U.s associated with the global critical care codes and the add-on codes for ECLS/ECMO and therapeutic hypothermia are found in Table 1.

Code	Description	wRVUs
99468	Initial critical care, 28 days or less	18.46
99469	Subsequent critical care, 28 days or less	7.99
99471	Initial critical care, 29 days–24 months	15.98
99472	Subsequent critical care, 29 days–24 months	7.99
33946	ECLS/ECMO provided by the physician, initiation, venovenous	6
33947	ECLS/ECMO provided by the physician, initiation, veno-arterial	6.63
33948	ECLS/ECMO provided by the physician, daily management, venovenous	4.73
33949	ECLS/ECMO provided by the physician, daily management, veno-arterial	4.6
99184	Initiation of selective head or total body hypothermia in a critically ill neonate	4.5

Table 1: RVUs by CPT Code[2]

Question:

A neonatologist attends a scheduled delivery of an infant with a known left-sided congenital diaphragmatic hernia. The infant is intubated, stabilized at delivery, and transferred to the NICU. The NICU team initiates a standardized protocol of care. The infant progresses through the protocol, requiring high-frequency ventilation, inhaled nitric oxide, and pressor support with afterload reduction. The echocardiogram reveals significant pulmonary hypertension with diminished left ventricular function. By the afternoon of day 1, the oxygenation index continues to hover around 40 for 4 hours when a decision is made to initiate veno-arterial ECMO. The pediatric surgeon successfully places the venous and arterial cannulas, and circuit management is turned over to the NICU team. What is the correct code(s) for the neonatologist?

A. 99469 – subsequent critical care, 28 days or less
B. 33947 – ECLS/ECMO initiation, veno-arterial
C. 33953 – insertion of peripheral (arterial and/or venous), open, birth through 5 years of age
D. 99469, 33947

Correct Answer: D. 99469 – subsequent critical care, 28 days or less, 33947 - ECLS/ECMO provided by physician, initiation, veno-arterial. The initiation of ECMO is an example of an add-on code, which recognizes the additional work associated with the complexity of this patient, exceeding traditional critical care. 33953 is for the insertion of the ECLS/ECMO cannulas, which the surgeon records. Should this infant continue requiring veno-arterial ECMO, the neonatologist would use the daily global code 99469 and code 33949, indicating the daily management of a veno-arterial ECLS/ECMO patient.

Question:

A term infant is delivered via emergency cesarean section due to placental abruption. The baby requires positive pressure ventilation, intubation, U.V.C. placement, and volume expansion at delivery. Cord venous gas reveals pH 6.8, pCO2 75, PaO2 19, BE -18. The infant is admitted to the NICU. The infant demonstrates seizure activity. By examination, the infant is in Sarnat stage 2. You place a U.A.C. for monitoring and decide to start total body cooling. The correct C.P.T. code(s) for NICU admission include:

A. 99468 – initial inpatient critical care
B. 99468, 36660 – catheterization umbilical artery
C. 99468, 99184 – initiation of hypothermia
D. 99468, 36660, 99184

Correct Answer C: 99468 – initial critical care, 28 days or less, 99184 – initiation of hypothermia. The umbilical artery catheterization is considered a bundled procedure with 99468. In this case scenario, the admission codes include the initial inpatient critical care and initiation of hypothermia. 99184 represents the initiation of selective head or total body hypothermia in critically ill neonates, recognizing the additional work required on the day body or selective head cooling is begun.

Discussion:

ECLS/ECMO and total body or selective head cooling represent critical care management options in patients that require additional work beyond that accounted for in the global daily critical care codes. Neonatology has successfully sponsored the current CPT® code sets and advocated for codes where additional work is required. As a brief review, the American Medical Association (A.M.A.) CPT® Editorial Panel is responsible for maintaining and updating the CPT® code set. The Editorial Panel is appointed by the A.M.A. Board of Trustees and supported by CPT® Advisors, physician representatives from the national medical specialty societies represented in the A.M.A. House of Delegates, and the A.M.A. Health Care Professionals Advisory Committee (HCPAC).[3]

"Category III codes are temporary codes for new and developing technology, procedures, and services created for data collection and analysis.3 Following data collection and assessment, these temporary codes were converted to Category I codes, then revised to include only the day of initiation for total body or selective head cooling. "

An example of this advocacy is found in the cooling code. The current cooling code evolved from an application resulting in two category III codes, 0260T and 0261T, total body cooling and selective head cooling, daily. Category III codes are temporary codes for new and developing technology, procedures, and services created for data collection and analysis.[3] Following data collection and assessment, these temporary codes were converted to Category I codes, then revised to include only the day of initiation for total body or selective head cooling.

References:

1. Duncan, S. "The Bundled Neonate: Neonatal Coding and Common Procedures. Neonatology Today 15(5): 58-59, 2020.
2. Centers for Medicare & Medicaid Services. PFS Relative Value Files [Internet]. Baltimore: Centers for Medicare & Medicaid Services; [cited 2023 Jun 14]. Available from: https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-relative-value-files/rvu23c
3. American Medical Association. CPT® overview and code approval [Internet]. Chicago: American Medical Association; [cited 2023 Jun 14]. Available from: https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval

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