Coding in the New Year, A Reason to Celebrate

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"The New Year also brings new CPT codes and revised coding guidelines for physicians. While many may sigh and some will cry, I am pleased to bring good tidings and cheer as the revised evaluation and management (E/M) inpatient codes are here!"

New Year's is celebrated worldwide as a day to let go of the past and embrace the future. Multiple traditions come to mind, such as singing Auld Lang Syne, making a resolution to lose weight, watching football in a Lazy-Boy, or nursing a hangover from the previous night's champagne. The New Year also brings new CPT codes and revised coding guidelines for physicians. While many may sigh and some will cry, I am pleased to bring good tidings and cheer as the revised evaluation and management (E/M) inpatient codes are here!

Effective January 1, 2023, inpatient E/M services (CPT 99221-99233) and inpatient E/M consult codes (99242-99255) will be billed based on medical decision-making OR the total time spent providing care on the day of the encounter. This contrasts the previous guidelines that required documentation of specific elements from the history, physical exam, and medical decision-making to support the billing code. The changes align with the revisions made to the 2021 outpatient E/M coding guidelines. It is anticipated that these changes will simplify the code selection, decrease the need for audits, and decrease unnecessary documentation.

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Although most neonatologists use the critical and intensive care CPT codes to bill for daily services, there are specific situations in which the inpatient E/M hospital care and consult codes are used. These include:

1) Admission and subsequent care of the not-so-normal newborn who does not require intensive monitoring and observation
2) Subsequent hospital care for babies who weigh > 5kg and require intensive monitoring and observation
3) Hospital admission care for infants > 28 days who do not meet critical care guidelines
4) Non-critical care consults
5) Inpatient perinatal consults

Consider this scenario:

A neonatologist is covering the special care nursery on New Year's Day and evaluates a 1-day-old, 5.2 kg term male infant born by cesarean section due to his large size. The neonatologist reviews the admission note and learns the infant's mother is a 33-year-old primigravida woman with poorly controlled diabetes. Physical exam reveals a large hypotonic well perfused, alert male infant with a cherub appearance and a grade II systolic murmur. Vital signs are normal. Pre-feed glucose levels range between 38-50 and improve to the mid-60s after feeding. The grandmother reports the infant breastfeeds poorly but has fair oral intake with bottle supplementation. The neonatologist concludes that the infant has neonatal hypoglycemia and poor feeding due to maternal diabetes. The plan consists of monitoring pre/post-feeding glucose levels, using glucose gel for glucose < 40, obtaining a lactation consult, and setting goal oral feeding volumes with a follow-up later in the day.

The neonatologist is concerned that the infant's murmur may be due to diabetic cardiomyopathy, so a chest radiograph is obtained. The neonatologist documents his findings, medical decision-making, and treatment plan. Later in the day, the neonatologist re-evaluates the infant, who remains alert and well-perfused. His feeding effort has improved, and he is meeting goal feeding volumes. Prefeed glucose is> 60 without the use of the glucose gel. The Lactation Consultant reports that breastfeeding is improving and will continue to assist the mother. Chest radiograph shows a mildly enlarged cardiac silhouette with clear lung fields consistent with diabetic cardiomyopathy, but since the clinical exam and vital signs are reassuring, further workup is deferred. The total time spent providing care on the day of the encounter is 60 minutes.

The correct code for this encounter is:

A: 99462 – Subsequent hospital care, normal newborn

B: 99477 – Initial hospital care, neonate ≤ 28 days, intensive care services

C: 99480 – Subsequent intensive care, infant not critically ill, weight 2501-5000gm

D. 99232 – Subsequent hospital care, moderate medical decision-making, 35-49 minutes

E. 99233 – Subsequent hospital care, high medical decision-making, 50 minutes

Answer E: 99233 – subsequent hospital care, high medical decision-making, 50 minutes.

This scenario meets the criteria for 99233, subsequent hospital care, high medical decision-making, and inpatient E/M code based on the level of medical decision-making. The level of medical decision-making is based on three categories: 1) the number and complexity of problems addressed, 2) the amount and complexity of data reviewed and analyzed, and 3) the risk of complications related to patient management. The highest decision-making level in two of the three categories defines the overall medical decision-making, ultimately determining the billing code. In this specific case, the physician is treating three acute problems requiring high-level decision-making: hypoglycemia that could threaten bodily function, poor feeding, and a new cardiac murmur of uncertain significance. The amount and complexity of data reviewed and analyzed also meet the criteria for high complexity. The physician reviews the glucose labs obtain an additional history from the grandmother, and orders ongoing glucose evaluations. Additionally, he independently reviews the chest radiograph and discusses breastfeeding management with a certified Lactation Consultant. Although the risk of morbidity from the treatment plan is moderate, the medical decision-making to address the problem and data categories meet the criteria for high-level decision-making; therefore, CPT code 99233 is billed.

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The alternative options listed above are not appropriate for this encounter. CPT code 99462, subsequent care for a normal newborn (Option A), does not apply because this patient is not a "normal" newborn and requires additional interventions beyond newborn care. Although this patient may meet the definition of intensive care services if he required continuous monitoring and dextrose support, the patient weighs > 5 kg and therefore does not meet the weight-based criteria for CPT code 99480 for daily intensive care services (Option C). CPT code 99477, intensive care admission for neonate < 28 days (Option B), is also incorrect because the neonatologist is providing ongoing care rather than an admission. However, the intensive care admission code 99477 could be used if the patient required intensive care on admission because this code is based on the patient's age, not the daily weight. Finally, CPT code 99232 subsequent hospital care, moderate decision making (Option D) is eliminated based on the criteria for levels of medical decision making.

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When documenting the encounter, it is important to address each category that supports medical decision-making. Unlike the previous inpatient codes, the documented details of the history and physical exam do not determine the code. Instead, the physician determines what parts of the history and physical exam are relevant in the documentation. The diagnosis, any comorbid conditions affecting the decision-making, and the patient's response to treatment should be specified in the medical record. Documentation of who provided the history, the external records reviewed, the data obtained and analyzed, and any *independent* reviews and *interpretation* of tests support the complexity of decision-making. Too often, a result is copied and pasted into the record without an interpretation. Finally, it is important to state the risk associated with management and treatment. Remember, a coder is not a mind reader! If it is not documented, it did not happen.

The above scenario may also be coded based on time. The total time documented by the neonatologist is 60 minutes which again meets criteria CPT code 99233, subsequent hospital care, high medical decision making, 50 minutes (option E). Time is the *total time* the clinician spends *on the day of the visit* providing patient care. This includes face-to-face time with the patient/caregiver AND non-face-to-face time spent by the clinician to manage the patient's problems regardless of the clinician's location. Time used to prepare for the patient's visit, such as record review, obtaining or reviewing the history, performing an exam, counseling/educating the patient/caregiver, documenting in the medical record, and coordinating care, is included if these activities are performed on the same day as the patient's visit. Time is not included for travel,

resident services, teaching, or performing separate services (such as a procedure). The revised guidelines eliminate the previous E/M requirement that at least 50% of the clinician's time must be spent face-to-face counseling the patient and coordinating care. Documentation for time-based coding should include the total time and a statement that the total time was spent "on the day of the patient visit."

"Because some inpatient E/M encounters require a significant amount of time, a new inpatient/observation prolonged care CPT code, 99418, has been introduced. This code is used when the total time to provide an inpatient E/M service with or without direct patient contact exceeds the highest level of service (99223 and 99233 for inpatient admission and subsequent care or 99255 for an inpatient consult)."

Because some inpatient E/M encounters require a significant amount of time, a new inpatient/observation prolonged care CPT code, 99418, has been introduced. This code is used when the total time to provide an inpatient E/M service with or without direct patient contact exceeds the highest level of service (99223 and 99233 for inpatient admission and subsequent care or 99255 for an inpatient consult). The prolonged service code is billed in 15-minute increments and may only be used when the encounter is billed based on time AND the time is performed on the day of service. For example, if the neonatologist had spent 70 minutes providing care instead of 60 minutes, he would bill 99418 in addition to 99233 for the additional time.

Whether you celebrate the beginning of the year by watching the ball drop, kissing at midnight, eating grapes, or smashing plates, I encourage you to let go of the old E/M guidelines and embrace the new coding changes. Happy New Year!

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