Eli's Rehab Report

Successfully Code Treatment of Pediatric Patients

PM&R practices and clinics often treat pediatric patients for conditions such as cerebral palsy (343-343.9), spina bifida (741-741.9) and brain injuries (850-854.1). Many PM&R caregivers are uncertain whether additional documentation and authorization are required to treat these patients and whether such documentation affects the pediatric coding. And some carriers do not reimburse for office visits for certain pediatric nonspecific diagnoses such as "generalized back pain." Practices that acquire parents' authorization, document all possible bullets on an E/M visit, and check their local review policies will be ahead of the game when coding for pediatric patients.

Getting Through the Exam

According to **Angel Rojas,** an independent coder in Miami, the first step in seeing or treating a pediatric patient is gaining the guardian's consent through writing. "Most practices have a standard form that says something like, 'This physician has my permission to treat my child,' because the guardian is responsible for handling the insurance and medical care."

Rojas also says some payers reject or question certain pediatric claims for higher-level office visits such as **CPT 99214** and **CPT 99215** . They don't believe that a child would require a complete past, family and social history section, or would be able to meet the requirements outlined in the bullets for the E/M documentation. However, she says, family history can be very important for these patients, as can the patient's own developmental history, so the physiatrist may spend a lot of time documenting those factors.

In patients suffering from conditions such as traumatic brain injuries, many E/M bullets can be counted if the physiatrist performs them differently for a pediatric patient than for an adult. For instance, normally a neurological exam includes bullets for items such as "orientation to time, place and person" and "recent and remote memory." A physiatrist might ask an adult patient to name the date and how he got to the doctor's office, whereas the physiatrist would ask a pediatric patient questions such as "Point to your mommy" and "What were you wearing when you woke up this morning?"

"Be sure the physiatrist documents what he or she did to fulfill each bullet on the E/M exam," Rojas says, "because if the insurer rejects the claim on these grounds, you want to be able to appeal it immediately."

Some bullets on the E/M documentation guidelines cannot be fulfilled by certain pediatric patients. For instance, if a patient cannot speak, the physiatrist may not be able to meet the "fund of knowledge" bullet on the neurological segment of the exam. But some brain-trauma patients can communicate in other ways. "If patients can understand questions but cannot speak, they may be able to answer fund-of-knowledge questions by nodding their heads," Rojas says.

For example, the physiatrist could ask the patient "Is the ocean purple?" or "Is two plus two nine?" to determine whether the patient can understand and answer such questions. In the documentation, you should list exactly what you asked the patient and how he responded to you, to ensure that your chart is complete.

It is important to note that some pediatric patients are too young to answer fund-of-knowledge or orientation-to- time questions because they haven't developed the language skills yet. Therefore, these bullets cannot be counted if the physiatrist is unable to perform them.

Coding for Treatments

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Many common PM&R treatments, such as nerve conduction studies (95900-95904) and needle EMG (95860-95872), are covered for conditions such as cerebral palsy, paraplegia (344.1 unless it is infantile, which is 343.0), spina bifida, back and neck pain (959.1 for back and 959.09 for neck), torticollis (723.5), spinal-cord injury (952-952.9) and brain injuries. "Contrary to popular belief," Rojas says, "a patient with neck pain does not have to be 18 years old before he is covered for diagnostic testing." She says that if a pediatric patient is diagnosed with such a condition and meets the requirements for medical necessity, then the physiatrist can bill for the service.

Therapist, Physiatrist Team

Most pediatric patients who see a physiatrist for neurological and musculoskeletal conditions are eventually referred to a physical or occupational therapist for additional care. Sometimes these patients are seen more often by the therapist than by the physician, says **Linda Johnson, PT,** a pediatric physical therapist in the department of PM&R at the University of California at Davis Medical Center.

"Some patients with conditions such as cerebral palsy or amputation will be coming in for therapy on a weekly basis, but they may only see their physician once a month. For that reason, it's important that the therapist and physician work together, particularly if any new problems crop up. We can only code and bill for therapy as long as the care is coordinated with the physician and the prescription for therapy is valid." The physiatrist must review and sign the treatment plan of record every 30 days. This is particularly important because the treatment plan is often the first thing asked for in an audit.

Most insurers will pay for a physiatrist's E/M visit and a physical or occupational therapist's evaluation or procedure for the same patient on the same day, assuming the diagnosis code is sufficient for the insurer to see the medical necessity for both services. For instance, if a physiatrist saw an established pediatric cerebral palsy patient for a level-three E/M visit, the patient then could go to the therapist for 30 minutes of neuromuscular re-education of movement and 15 minutes of gait-training.

This would probably be coded using 99213 with the physiatrist's identification number, and then two units of 97112 (it's billed in 15-minute increments, so a half-hour would be two units) for the neuromuscular re-education, and one unit of 97116 for the gait-training, both using the therapist's identification number.

"Our orthopedic-centered pediatric patients, who have rheumatologic or amputation diagnoses, would usually have therapeutic exercise (97110) and gait-training (97116)," Johnson says. "On occasion, we will take our pediatric patients into the pool and bill aquatic therapy (97113) for that."

These conditions can be covered for pediatric patients if all requirements for medical necessity have been met. Documenting for therapy can be extensive, because insurance carriers require that the therapist be able to prove that the patient is moving toward a functional goal and has the ability to improve.

Pediatric Therapy Documentation Must Be Perfect

All documentation for pediatric therapy should note the time devoted to each therapeutic treatment, the person who provided the care, and each modality performed. The patient's chart should include a copy of the current treatment plan with signatures of the supervising physiatrist and physical or occupational therapist, as well as permission from the patient's guardian. Documentation must also include the date the physiatrist last saw the patient.

Due to pediatric claims being scrutinized more than adult claims, it is imperative that the patient's plan of care be up-to-date and well-documented. Every plan of care should include the following:

1. **The patient's significant past history.** For instance, "spina bifida since birth in this 6-year-old female patient with no other significant problems ..."
2. **Patient's diagnoses that require therapy.** If the spina bifida has caused other problems, such as gait abnormalities, include all the applicable diagnoses.

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3. **Related physician orders.** Include the physiatrist's prescription for therapy, and if other specialists are involved, their documentation as well.
4. **Therapy goals and potential for achievement.** Be specific: Use statements such as "Expectation is for patient to take three concurrent steps without assistance within the next three weeks. Because she was able to take two-and-a-half steps at the end of last month, and she has been performing strength training on her legs and hips, we believe she will be able to achieve this goal." Therapists who are vague in their goals are at risk for negative audits. For instance, statements like "Our goal is for Susan to walk someday" are not specific enough.
5. **Any contraindications.** If the patient recently fell out of her wheelchair and bruised her hip, indicate that this may be a setback but not a reason to discontinue therapy.
6. **Patient's awareness and understanding of diagnoses, prognosis and treatment goals.** For instance, "Susan is aware of the fact that she may not be able to abandon her wheelchair this year, but she believes that the balance and exercise training will help her to reach this goal within the next three years."
7. **When appropriate, the summary of treatment provided and results achieved during previous periods of therapy services.** According to Johnson, pediatric patients with chronic conditions such as cerebral palsy often receive therapy for years. Therefore, comparisons with previous therapy periods can prove that the patient is meeting specific goals. Statements such as "Despite the fact that John couldn't stack three blocks on top of one another last year, he is now able to make side-by-side towers of 16 blocks each without knocking either one down" can help demonstrate that the therapy is working.

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