American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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Dear Medical Director:

The American Academy of Pediatrics (AAP), representing over 67,000 pediatricians, pediatric medical sub-specialists and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents and young adults, is advocating for coverage and payment for new CPT codes that are effective January 1, 2019. The AAP urges all payers to pay interprofessional consultation services, when appropriately reported by a treating/requesting provider or consultant. In addition, two new developmental testing codes have been added and the existing developmental testing code was deleted (96111).

Since the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the "version of the medical data code sets specified in the implementation specifications must be the version that is valid at the time the health care is furnished," covered entities must incorporate the new codes into their claims processing systems by January 1, 2019. We want to inform you of these new codes and ascertain how your claims systems and payment edits will pay on claims reporting the following:

Interprofessional Consultations: While 4 codes have existed for quite some time (99446-99449), these codes were previously listed as a 'B' or bundled status on the Medicare Resource-Based Relative Value Scale (RBRVS). However, in 2019 they will be assigned 'A' or active status and thus separately payable.

▲**99446** *Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review*
▲**99447** *11-20 minutes of medical consultative discussion and review*
▲**99448** *21-30 minutes of medical consultative discussion and review*
▲**99449** *31 minutes or more of medical consultative discussion and review*

In addition, there will be two new interprofessional consultation codes as follows:

●**99451** Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time

●**99452** Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

Code 99451 is reported by the consultant when the criteria for reporting the 99446-99449 are not met, such as no verbal report and/or less than 50% of the total consultative time

spent in in the consultative service (ie, more than 50% is spent on data review and interpretation).

Code 99452 is reported by the treating/requesting physician for time spent preparing for the consult and in medical discussion with the consultant.

Both codes are only reported for non-direct patient time.

2019 RBRVS includes all six (6) codes as status 'A' (Active), with the values as follows:

CPT	Status	Work RVUs	PE RVUs	Malpractice RVUs	Total RVUs	Global
99446	A	0.35	0.14	0.02	0.51	XXX
99447	A	0.70	0.27	0.04	1.01	XXX
99448	A	1.05	0.41	0.06	1.52	XXX
99449	A	1.40	0.54	0.08	2.02	XXX
99451	A	0.70	0.29	0.05	1.04	XXX
99452	A	0.70	0.29	0.05	1.04	XXX

These codes are particularly important for those patients who may lack access to certain specialists or when time is a factor in getting medical advice from a specialist or primary care physician. These codes allow each separate service to be reported for the treating/requesting physician (ie, 99452) and the consultant (ie, 99451), given that neither provider will see the patient within 14 days of the date of service. As noted above, the status for all six codes is 'A' status, indicating that they are now payable on under Medicare payment policy.

Developmental Testing: On January 1, 2019, developmental testing code 96111 will be deleted and replaced with two new, time-based codes.

●**96112** Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

✚●**96113** each additional 30 minutes (List separately in addition to code for primary procedure)

These codes are meant to represent the total time spent in administration, interpretation and report, even if that time is not continuous or on the same day. It represents an episode of care for the patient.

2019 RBRVS

CPT	Status	Work RVUs	NF PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Total NF RVUs	Total Facility RVUs	Global
96112	A	2.56	1.13	0.91	0.14	3.83	3.61	XXX
96113	A	1.16	0.48	0.42	0.07	1.71	1.65	ZZZ

The Academy urges all payers to provide appropriate payment for reported developmental screening services that reflect (at minimum) the total relative value of the service as shown in the table above.

Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden

The 2019 RBRVS final rule established a framework for future changes to the office/other outpatient E/M services. While these changes will be implemented incrementally, the following changes become effective in 2019:

- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has *changed since the last visit, or on pertinent items that have not changed*, and do not need to re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so.
- For new or established office/outpatient visits, practitioners do not need to re-enter information in the medical record on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. *The practitioner may simply indicate in the medical record that he or she reviewed and verified this information*.
- Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.

The AAP is charging all payers to follow these important updates to the E/M rules and in turn require that their auditors be aware of these updates and audit charts accordingly. Simply put, the physician no longer has to re-document previous exam elements that, while relevant to the current encounter, have not changed since the previous encounter. In addition, previously it was understood that the history of present illness or HPI was required to be documented by the reporting provider. That is no longer the case and simply must be verified and updated as appropriate.

The Academy encourages all payers to provide coverage benefits and pay appropriately for these new codes as separately reported services. Therefore, w***e request your coverage and payment policy(ies) for the above listed CPT codes including how your auditors will be required to follow CMS E/M documentation rules.***

We look forward to your response on your coverage and payment policy for these new CPT codes. If you have questions or need additional information, please contact Lou Terranova, Senior Health Policy Analyst at lterranova@aap.org or 630-626-6633.

Sincerely,

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