AAPC

CPEDC™

Certified Pediatrics Coder

STUDY GUIDE

2026

2026

Specialty Study Guide: CPEDC™

PEDIATRICS

Contents

2026 Specialty Study Guide: CPEDC™ Introduction

The *Specialty Study Guide: CPEDC™* is designed to help pediatrics coders, billers, and other medical office professionals prepare for the CPEDC™ examination. This guide is by no means comprehensive. Your primary resource for the exam will be your years of hands-on experience in coding for pediatrics.

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a CPEDC™ shows your expertise in pediatric coding. Membership in AAPC lends integrity to your credentials and provides a large network of coders for support and allows you access to continuing education opportunities. The *Specialty Study Guide: CPEDC™* is designed to provide an overall review of coding and compliance information for the more experienced coder, as well as for someone preparing for the CPEDC™ examination.

We will review the importance of using the coding guidelines within ICD-10-CM and CPT®, as well as emphasize the importance of correct evaluation and management (E/M) services leveling. You will need 2026 versions of ICD-10-CM, CPT®, and HCPCS Level II code books for this study guide and for your CPEDC™ exam.

ICD-10-CM Coding

Proper diagnostic coding not only reports the medical necessity of procedures performed, but also contributes to data that determines health policies for tomorrow. Because physicians have traditionally been paid by CPT® code values, coders have sometimes given little importance to correct ICD-10-CM coding. Regulatory trends show that diagnoses will play a larger role in reimbursement in the future. It is important to code correctly now, so that you can be prepared for that day.

We will discuss the major topics of diagnosis coding for evaluation and management. The examinee must be familiar with the Official Coding Guidelines for ICD-10-CM. The examinee must know how to select the appropriate ICD-10-CM codes as well as the proper sequencing of diagnosis codes when more than one diagnosis code is required to report a patient's condition(s). The examinee must understand the conventions, general coding guidelines, and chapter specific guidelines in the ICD-10-CM code book.

Evaluation and Management Coding

Office visits consume a lion's share of the physician's time in most practices, and consequently represent the largest revenue source. Compliance is an increasing concern at practices; the E/M material in this study guide will focus on the E/M services for pediatrics and underscore the importance of modifier use. An understanding of the AMA E/M guidelines and subsection notes in the CPT® code book is an important foundation for accurate code selection that is provided in your CPT® code book.

An E/M calculator is provided for the online exam (https://www.aapc.com/codes/em-calculator) and your CPT® code book provides a Medical Decision Making (MDM) table to level an E/M service..

CPT® Coding

Surgical procedures specific to pediatrics will be discussed in this section. Special attention will be given to the guidelines and parenthetical phrases associated with procedures. Understanding CPT® coding conventions will be helpful as well. The examinee must be able to select the appropriate CPT® codes and sequence the codes correctly when multiple procedures are performed. CPT® codes are sequenced based on the most complex or labor-intensive procedures. The codes with the highest RVUs (Relative Value Units) are sequenced first.

Top 10 Missed Coding Concepts

We will review the Top 10 Missed Coding Concepts for the CPEDC™ certification exam. The list is not presented in any specific order. The information is determined after an evaluation by the AAPC exam department of the commonly missed questions on the exam.

Practice Exam

The practice exam and the exam were written by coders with extensive experience in coding for pediatrics. The practice exam mimics the format and structure of the CPEDC™ certification exam.

AAPC has developed specialty credentials to enable coders to demonstrate superior levels of expertise in their respective specialty disciplines. Here is information on the CPEDC™ credential:

- CPEDC™ stands alone as a certification with no prerequisite that the examinee holds a CPC® or COC® credential.
- Exams aptly measure preparedness for real world coding by being entirely operative/physician-note based. These operative (op) notes are redacted op notes from real pediatrics practices.

The CPEDC™ examination tests your knowledge of coding concepts, anatomic principles, and coding guidelines only. When you take this exam, remember that individual payer rules are not a consideration when choosing the right answer. Unless it is specifically stated in the case note or exam question that the patient is covered by Medicare, you should follow the CPT® coding guidelines.

The exam tests competency. The candidate most qualified to pass the exam will be proficient in understanding:

- Medical terminology and anatomy
- Medical physiology
- Teaching physician guidelines
- Incident-to guidelines
- Split/Shared services
- HIPAA regulations
- Proper use of an Advance Beneficiary Notice of Noncoverage (ABN) form
- ICD-10-CM coding
- E/M code selection using the AMA CPT® E/M guidelines
- CPT® coding for common procedures
  - 10000 Series
  - 20000 Series
  - 30000 Series
  - 50000 Series
  - 60000 Series
  - Laboratory and Pathology
  - Radiology
  - Medicine
  - Category III codes
- CPT® and HCPCS Level II modifier usage
- HCPCS Level II coding

Familiarity with practical coding and the code books is essential, as time is an important element in successfully completing the exam. Approach the exam as you would approach your work—by demonstrating coding abilities essential to success. This is not a general aptitude test, and each question has a specific goal for measuring your competency. The practice exam within the *Specialty Study Guide: CPEDC™* course is highly representative of the subject matter and level of difficulty you will encounter in the full-length exam.

Test Answers and Rationales

The final chapter in the book contains the answers to the practice exam. Accompanying each answer is a rationale that explains the coding guidelines contributing to selecting the right answer. These rationales should help you understand what is needed to successfully approach and answer questions on the real exam, because they allow you a glimpse into the minds of the test's creators.

Examinees that pass the CPEDC™ certification examinations will receive recognition in AAPC's monthly magazine, *Healthcare Business Monthly,* and receive a diploma suitable for framing.

About AAPC

AAPC was founded in 1988 in an effort to elevate the standards of medical coding by providing training, certification, ongoing education, networking, and recognition.

AAPC provides medical coding certification exams for coders in physician practices and the outpatient/facility environment. AAPC has expanded beyond outpatient coding to include training and credentials in documentation and coding audits, inpatient hospital/facility coding, regulatory compliance, and physician practice management. The purpose of AAPC coding certifications is to test an examinee's knowledge of coding principles and proficiency in coding accurately and efficiently. AAPC examinations measure a coder's skill of both coding accuracy and efficiency.

AAPC Member Code of Ethics

Members of AAPC shall be dedicated to providing the highest standard of professional service for the betterment of healthcare to employers, clients, vendors, and patients. Professional and personal behavior of AAPC members must be exemplary.

It shall be the responsibility of every AAPC member, as a condition of continued membership, to conduct themselves in all professional activities in a manner consistent with ALL of the following ethical principles of professional conduct:

- Integrity
- Respect
- Commitment
- Competence
- Fairness
- Responsibility

Adherence to these ethical standards assists in assuring public confidence in the integrity and professionalism of AAPC members. Failure to conform professional conduct to these ethical standards, as determined by AAPC's Ethics Committee, may result in the loss of membership with AAPC.

Introduction to ICD-10-CM Coding Guidelines

The National Center for Health Statistics (NCHS) developed ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) in consultation with a technical advisory panel, physician groups, and clinical coders to assure clinical accuracy and utility. ICD-10-CM coding guidelines are developed by the Centers for Medicare & Medicaid Services (CMS) and the NCHS. Healthcare providers must begin using the most recent ICD-10-CM code revisions on Oct. 1 of each year, with no "grace period" to transition to the changes.

All versions of the ICD-10-CM code book typically include the ICD-10-CM Official Guidelines for Coding and Reporting. These guidelines are an invaluable source for diagnosis coding information and provide instruction supplemental to that found in the Tabular List and the Alphabetic Index of the ICD-10-CM code book.

ICD-10-CM codes are utilized to facilitate payment of health services, to evaluate utilization patterns, and to study the appropriateness of healthcare costs. Case-by-case success in achieving these goals requires an open line of communication between the coder and the documenting physician.

The Official Guidelines note, "A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." Each ICD-10-CM code assigned must be supported by documentation linked to that claim (individual dates of service must stand alone), and coders must be mindful not to assume or extrapolate information from the medical record (for instance, coding a condition as acute when it isn't documented as such).

The Official Guidelines are divided into four sections:

- Section I - ICD-10-CM Conventions, General Coding Guidelines, and Chapter Specific Guidelines.
- Section II - Selection of Principal Diagnosis. The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- Section III - Reporting Additional Diagnoses. This section gives rules for diagnoses other than the principal diagnosis that affect the patient's care.
- Section IV - Diagnostic Coding and Reporting Guidelines for Outpatient Services. This section includes information about coding signs and symptoms, when to report chronic diagnoses, ambulatory surgery, routine outpatient prenatal visits, and more.

General Tips for Using ICD-10-CM

Use the Alphabetic Index and Tabular List of the ICD-10-CM code book together to determine the diagnosis code. When attempting to select an ICD-10-CM diagnosis code, begin by searching for the main term—such as "lesion," "burn," etc.—in the Alphabetic Index. Follow all cross-references and "*see also*" entries. When you have located the code you are seeking, turn to that code in the Tabular List. Be sure to pay close attention to disease definitions, footnotes, color-coded prompts, and other instruction. Read all supplemental information completely to be certain you are choosing the correct code. Always select a diagnosis to the highest level of specificity supported by the available documentation.

The first-listed diagnosis should describe the most significant reason for the procedure or visit. The first-listed diagnosis will be reflective of the patient's chief complaint. Relevant co-existing diseases and conditions, as well as related history or family history conditions, are reported as secondary diagnoses. When coding preexisting conditions, make sure the assigned diagnosis code identifies the current reason for medical management. Do not report conditions that no longer exist, or do not pertain to the visit.

Many patients will have numerous chronic complaints. Report a chronic complaint diagnosis only when that chronic condition is treated or becomes an active factor in the patient's care.

Always select ICD-10-CM codes to the highest level of specificity supported by documentation. For example, diagnosis coding for fractures of the wrist and hand requires a 5th code character (which specifies location), a 6th code character (which specifies the laterality and whether the fracture is displaced or nondisplaced), and a 7th code character (which specifies the episode of care). If this information is not documented, appropriate code selection is impossible. You should work with your provider to ensure that the information necessary for proper coding is always noted.

General ICD-10-CM Guidelines

Signs/Symptoms and Confirmed/Unconfirmed Diagnoses

Use of codes that describe signs and symptoms are acceptable when the provider has not established a related, definitive diagnosis. Report only confirmed diagnoses. Uncertain diagnoses described as "probable," "possible," "suspected," "likely," "rule out," "consistent with," "compatible with," etc., are not coded. Code the highest level of certainty known, using codes that describe known signs, symptoms, abnormal test results, etc.

For example, if a patient has a breast mass and the provider suspects breast cancer, you should not report breast cancer as the diagnosis. Instead, report the signs and symptoms, such as breast mass, that prompted the exam. If testing later confirms cancer, only then should you report the cancer diagnosis.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, report any confirmed or definitive diagnosis(es) documented in the interpretation. If a definitive diagnosis is known, do not code related signs and symptoms as additional diagnoses. That is, if the test is positive, you report the findings. For tests interpreted as normal, code the condition, symptom, or sign that necessitated the diagnostic study.

In rare occurrences, a test is ordered without a clear indication of reason, and the ordering physician is not available to gather enough information prior to treating the patient. In such a case, you will want to confirm with the order for the physician's reason(s) that the test was ordered.

When you are provided with both a preoperative and postoperative diagnosis, always report the *postoperative* diagnoses codes if the pre- and postoperative diagnoses differ.

Signs and symptoms attributable to a definitive diagnosis should not be reported separately. Cite additional signs and symptoms beyond the primary diagnosis only when those signs and symptoms are not integral to the disease process. Report only those additional conditions that affect treatment, and that the provider documents for the current visit.

For example, a patient presents with shortness of breath. The next day, the physician determines the patient has pneumonia but he feels that the shortness of breath may be due to a cardiac condition. In such a case, you may still report the shortness of breath as a sign and symptom with pneumonia because the physician has documented reason to believe that the conditions are unrelated.

Above all, do not extrapolate or assume information. Select codes only from what is apparent in the available documentation.

Acute vs. Chronic

The doctor makes the determination as to when a condition becomes chronic. Coders will select an appropriate code for acute or sub-acute (primary) versus chronic (secondary) based on the available documentation. For example, a torn meniscus (S83.2-) will become an internal derangement of knee (M23.-) after a defined period of time.

If a patient's condition is *both* acute/sub-acute and chronic, and a single code does not describe this combination, the ICD-10-CM code book provides instruction to report the acute (sub-acute) code first and the chronic code secondary.

Sequela (Late Effects)

Sequela (late effects) codes are usually reported as secondary diagnoses, with the effect or reason for the visit as primary. There is no time limit (such as 90 days, one year, etc.) in which late effects can occur.

Sequela (late effects) of cerebrovascular disease fall specifically to category I69, which indicate conditions classifiable to I60-I67 (hemorrhage, occlusion, and stenosis, etc.) as the cause of sequela (late effects). Guidelines indicate that the late effects include neurologic deficits caused by cerebrovascular disease and may be present from the onset or may arise at any time after the onset of the condition—classifiable to categories I60-I67. A code(s) from category I69 may be assigned on a health case record with codes from I60-I67 if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA.

Some of the codes in category I69 that specify hemiplegia, hemiparesis, and monoplegia also identify whether the dominant or nondominant side is affected. If the dominance is not stated (right-handed, left-handed, or ambidextrous), and the classification does not indicate a default, then the following applies:

- For ambidextrous patients, the default is always dominant.
- If the left side is affected, the default is nondominant.
- If the right side is affected, the default is dominant.

Multiple Conditions Reported with a Single Code

In some cases, ICD-10-CM will employ a single code to describe two or more conditions concurrently, such as a primary diagnosis with an associated secondary process (manifestation), or a primary diagnosis with an associated complication. Category I12, for instance, describes hypertension with chronic kidney disease and K81.2 describes acute and chronic cholecystitis; two separate codes are not necessary to describe these concurrent conditions.

Evaluation and Management Coding for Pediatrics

This chapter examines the documentation requirements for the evaluation and management (E/M) codes used by physicians and non-physician practitioners (NPPs) to bill for their services.

The E/M documentation requirements chapter is designed to provide a detailed approach to the accurate identification of documentation elements as they are defined by the American Medical Association (AMA) Guidelines for E/M services. The goal of this material is to offer the necessary insight to develop proficiency and correct technique to accurately select levels of E/M services for the exam. This material is not meant to influence policy, rather to refer to as coding guidelines for the CPEDC™ exam.

This chapter should be reviewed with the CPT® guidelines for E/M services found in the current CPT® code book. This guide is a general summary that explains commonly accepted aspects of selecting E/M codes. The goal is that, after completing your training, you will be confident that you will not under or over code a visit.

An Introduction to the Documentation Requirements Associated with E/M Services

The E/M Documentation Guidelines (DGs) have perhaps inspired more discussion than any other non-clinical topic based in the industry. In an ever-increasing effort to ensure that correct payments are made for visits and consultations, Medicare and the AMA have been working together for well over a decade. In 1992, Medicare transitioned to the Resource-Based Relative Value Scale (RBRVS) physician payment system and the AMA introduced E/M codes in CPT® to report visits and consultations.

By 1994, in response to confusion and the inaccurate interpretation of the codes, the Office of Management and Budget mandated that Medicare adopt DGs to expand the definition that was, at that time, only provided by CPT®. Medicare and the AMA jointly developed this initial set of E/M DGs which were deployed in 1995 and became known as the 1995 Documentation Guidelines or DGs. As auditing showed a pattern of continued misuse of the E/M Codes, the 1995 DGs were criticized as unfair to specialists because they seem to account for extended single system examinations with as much weight as limited multiple system exams.

Within two years, the E/M DGs were revised to improve physician and provider understanding and payment accuracy by extending the definitions to include specialty specific guidance. This set of DGs was scheduled to replace the 1995 DGs and became known as the 1997 DGs. The only problem was that the physician community loudly objected to the 1997 DGs. They were criticized as burdensome with documentation requirements that were too detailed and very difficult to achieve. Medicare decided to not replace the 1995 DGs but to instead allow physicians and providers to choose between the 1995 and the 1997 DGs.

In 2021, in an attempt to simplify the guidelines, the AMA changed the descriptions of the Office or Other Outpatient E/M Services codes 99202-99215. In addition, guidelines for the use of these codes were printed in the CPT® code book. The guidelines added in the 2021 CPT® code book were specific to Office or Other Outpatient E/M Services. In 2023, the AMA expanded the use of the guidelines introduced in 2021 to other E/M categories, eliminating the need for the 1995 and 1997 DGs.

Documentation Guidelines

There are three general principles regarding documentation to ensure credit can be thoroughly verified. It is important to follow these rules of thumb:

1. Documentation should be legible to someone other than the documenting physician or provider and their staff.
2. The date of service, name of the patient, and the name of the provider of service should be easily demonstrated by the documentation.
3. The documentation should support the nature of the visit and the medical necessity of the services rendered.

For most E/M visits, the provider performs three main components: history, exam, and medical decision making (MDM). The history directs the provider to troubleshoot the chief complaint based on an interview with the patient. The exam portion is the provider's physical exam and evaluation of the patient. The MDM includes the provider's assessment and plan.

The guidelines for E/M Services, along with the code descriptors, indicate that a "medically appropriate history and/or physical examination, when performed" is included in the service. While the history and exam should be documented, they are not used in the determination of the level of the code.

The guidelines also include pertinent definitions for terms necessary to understand when determining the level of MDM. You should read through the definitions provided in your CPT®

code book and refer back to them as we go through the MDM components below.

The E/M guidelines provide instructions for selecting the appropriate level of service based on either of the following:

1. The level of the MDM as defined for each service; or
2. The total time for E/M services performed on the date of the encounter.

The provider can determine to support the E/M level of the visit based on MDM or time on a case-by-case basis. Regardless of which element is used to determine the level of visit, documentation should support the medical necessity of the visit. Payers may also have regulations on when MDM or total time is used.

Determining the Medical Decision Making (MDM)

The MDM most accurately reflects the amount of work a provider performs during an E/M service. Four levels of MDM are recognized: straightforward, low, moderate, and high. The level of MDM directly correlates to a level of service.

EXAMPLE: OFFICE VISIT MDM TO CODE CORRELATION

New Patient Code	Established Patient Code	Level of MDM
	99211	N/A 99211 is reported for services that typically do not require the presence of a provider. As such, the concept of MDM does not apply to code 99211.
99202	99212	Straightforward
99203	99213	Low
99204	99214	Moderate
99205	99215	High

To adequately determine the level of visit, the MDM is selected based on three components:

1. The number and complexity of problems addressed at the encounter;
2. The amount and complexity of data to be reviewed and analyzed; and
3. The risk of complications and/or morbidity or mortality of patient management.

To determine the levels of these components appropriately, the definitions provided in your CPT® code book must be understood. Using a grid method, we will discuss each component. Be sure to refer back to the definitions listed in the E/M Guidelines as needed.

Number and Complexity of Problems

The number and complexity of problems identifies the nature of the presenting problem and is based on the relative difficulty level in making a diagnosis. For the problem to be considered in the number of problems, the problem must be addressed within that encounter.

Per CPT®, symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of lower severity may, in aggregate, create higher risk due to interaction.

The final diagnosis alone does not determine the complexity or risk to the patient. The documentation should be reviewed for comorbidities or underlying diseases that are addressed that increase the level of risk to the patient. Simply listing a chronic illness in the documentation is not sufficient. The documentation should indicate that the provider addressed the conditions during the encounter or that the condition contributed to the severity of the case.

When a patient sees multiple providers for different aspects of their care, you may see a physician document the condition is being managed by another provider. When the documentation only states that the patient has the condition and that it is being treated by another provider, it is not considered for the leveling of the visit. If there is additional documentation showing assessment or care coordination regarding that diagnosis, other than the statement of the condition being treated by another provider, it is then considered toward the level of service.

TESTING TECHNIQUE

Read through the entire note to get an understanding of the conditions that are addressed and analyzed during the visit. Simply relying on the chief complaint will not always give an accurate description of the number and complexity of problems for the encounter.

There are four levels identified under the number and complexity of problems addressed; minimal, low, moderate, and high. As demonstrated by the table below, the level of Number/Complexity of Problems Addressed increases as the difficulty of the patient's health increases.

In this chapter, we will discuss pediatric coding for newborns, critical care, preventive care, modifiers, and non-face to face services. Also discussed are common procedures performed in a pediatric practice which include venipuncture, strep tests, cerumen removal, foreign body removal, wart removal, lesions, simple repairs, circumcisions, aerosol treatments, postoperative visits, and suture removal.

Newborn Services

When selecting the appropriate code for a newborn (birth through the first 28 days), you must take into consideration the condition of the neonate or newborn and the intensity of the service provided and documented on the day of service.

Codes 99460–99461 are selected for the initial inpatient care of a normal newborn. The distinction between the codes is the site of service. If the service is performed in the hospital or birthing center, report 99460. This code is for a newborn that is not sick and it is for the initial newborn history and physical examination.

If the service is reported in a site other than hospital or birthing center, report 99461. There is only one code for subsequent care: 99462. This code is also for a newborn that is not sick. If a newborn is ill but does not require critical care or continuing intensive care services, report a subsequent hospital or observation care code 99231–99233 based on the performance and documentation of the required medical decision making components.

If the newborn is admitted and discharged on the same date of service, report 99463.

When discharge management services are provided on a day other than the date of admission, report the appropriate discharge code based on time (99238–99239).

When a physician attends a delivery at the request of the delivering physician, report 99464. There must be documentation of the request for attendance at the delivery and the documentation must substantiate the services performed. The attendance at delivery may be reported with the initial newborn, sick newborn, intensive care of the neonate, or the critical care codes. Also, if any medically necessary procedures are provided in the delivery room, they may be reported in addition to code 99464.

When resuscitation is necessary in the delivery or birthing room, report 99465. These services include positive pressure violation and/or chest compressions in the presence of an acute inadequate ventilation and/or cardiac output. If other services are performed, they may be reported separately. The physician must document the need for and the list of resuscitative measures provided. This documentation will distinguish the service (99465) from the attendance at delivery (99464). Code 99465 cannot be reported with 99464.

Physician standby services require prolonged physician or other healthcare professional attendance without direct face-to-face patient contact. The physician or other healthcare professional must be immediately available and physically present to provide any necessary care and may not provide services to any other patient at the same time. This service must be requested by another physician and the request must be documented in the medical record. Standby services are reported for each full 30 minutes of standby time. This code is not reported if the physician performs the procedure.

Inpatient Neonatal and Pediatric Critical Care

When coding for inpatient neonatal and pediatric critical care, you must pay special attention to the age of the neonate, infant or young child to ensure you choose the appropriate code. Code 99468 is used for your initial inpatient neonatal critical care per day for the evaluation and management of a critically ill neonate 28 days of age or less. For subsequent inpatient neonatal care for patients age 28 days or less, report 99469. It is also important to know the services that are bundled with the critical care services. A list of the services bundled with neonatal and pediatric critical care is included in the coding guidelines found in this subcategory. There is also instruction in the CPT® guidelines that the services bundled with 99291 and 99292 are also bundled with the pediatric and neonatal critical care codes. Examples of services that are bundled include: endotracheal intubation, insertion of central venous lines, and umbilical venous catheters. The complete list can be found in the CPT® code book. If critical care services are performed in the outpatient setting (emergency department), report 99291 and 99292, NOT 99468-99476, regardless of the patient's age.

These codes represent care starting with the date of admission and subsequent days that the neonate remains critical. These codes may be reported only by a single physician and only once per day, per patient.

Code 99468 can be used in addition to 99464 or 99465, as appropriate, when the physician is present for the delivery or resuscitation.

Code 99471 is used to report initial inpatient critical care per day for the evaluation and management of a critically ill infant or young child 29 days through 24 months of age. And code 99472 reports the subsequent care for the critically ill infant or young child, age 29 days through 24 months of age.

Code 99475 reports initial inpatient pediatric critical care for a child two through five years of age and 99476 is the subsequent inpatient critical care ages 2 through 5 years.

Remember that the same definition for critical care services applies when coding for the adult, the child, and the neonate. Always review the criteria in CPT® to be sure that you are using the correct codes. CPT® defines critical care as, "Direct delivery by a physician of medical care for a critically ill or injured patient. A critical illness or injury acutely impairs one or more vital organ such that there is a high probability of imminent or life-threatening deterioration in the patient's condition."

Intensive Care Services

These codes should be reported when a neonate or infant is not critically ill but requires intensive observation, frequent intervention, and other intensive care services. Code 99477 is for the initial hospital care for the evaluation of the neonate 28 days of age or less who is going to require intensive observation.

Code 99478 is reported for subsequent intensive care and this is for the recovering very low birth weight infant when the present body weight is less than 1,500 g. Code 99479 is present body weight of 1,500 g to 2,500 g. Code 99480 is reported for present body weight of 2,501 g to 5,000 g.

Pay special attention to the subsequent intensive care codes, which are determined by weight, not age. These codes were changed in 2009 to reflect present body weight instead of birth weight.

Pediatric Critical Care Patient Transport

Codes 99466 and 99467 are reported based on time for critical care services delivered by a physician, face-to-face, during an inter-facility transport of a critically ill or critically injured pediatric patient. For patients 24 months of age or less, the first 30 to 74 minutes of hands-on care during transport is reported with 99466. Code 99467 is reported for each additional 30 minutes.

Some examples of who may need transport include a patient who has a high, uncontrollable fever, or a patient who has severe trauma or a head injury.

Preventive Care

There are two code sets for preventive care: Codes 99381-99387 are reported for new patients and codes 99391-99397 are reported for established patients.

These codes report a routine physical examination performed each year for infants, children, adolescents, and adults, and therefore differ according to the age of the patient. Use these codes to report all preventive medicine, evaluation and management (E/M) services such as annual physicals, Early and Periodic Screening, Diagnosis, and Treatment programs (EPSDTs), school physicals, sports physicals, driver's license exams, and working paper physicals.

Modifiers

Modifiers are appended to procedure codes to identify a procedure has been altered in a specific way without changing the code description itself. Modifiers can be informational or effect reimbursement. Proper modifier use is crucial for appropriate reimbursement. The most common modifiers used are:

Modifier 25

Modifier 25 is used to identify a significant and separately identifiable E/M service. An example is if the physician or other healthcare professional treats a problem or abnormality that requires significant work during a preventive medicine visit. Both the well visit and the problem-oriented service can be reported on the same day. Append modifier 25 to the problem-oriented service. Documentation must support that additional work.

Before you bill for the additional E/M service, it is always good to ask yourself these five questions:

1. What is the intent of the visit?
2. Is it a minor problem that is addressed?
3. Will the patient return?
4. Is the additional problem significant?
5. Does the documentation support both services?

Top 10 Missed Coding Concepts on CPEDC™ Examination

Not in particular order, the tips provided below are based on AAPC's Exam Department observations of the most missed coding concepts.

1. **Circumcision:** Report 54150 when a clamp or other device is used to perform a circumcision. The procedure includes a dorsal penile or ring block. If a block is not performed, report 54150-52. Report 54160 or 54161 based on the patient's age when a device is not used to perform a circumcision.

2. **Parenthetical Instructions:** Refer to the parenthetical instructions in the CPT® codebook for reporting codes 69209 and 69210. To report these codes the cerumen needs to be impacted. If the cerumen is not impacted, you report an E/M service code.

3. **AMA E/M Guidelines for Selecting the Level for the Amount and/or Complexity of Data to be Reviewed:** When assessing the *Amount and/or Complexity of Data* in MDM, whether a test can be counted depends on whether it is separately reportable. If a diagnostic test is ordered, performed, and/or interpreted during the encounter—and the physician bills separately for the professional interpretation—then the test does not count toward data in the E/M service. For tests that include a separate interpretation (such as X-rays or ECGs) performed in the office, it is assumed the provider will bill for the interpretation, so the ordering of that test cannot be counted as a unique test. In contrast, tests that do not require separate interpretation, such as laboratory studies with immediate results only (e.g., rapid strep test), may be counted as ordered or reviewed when they contribute to medical decision making. At a follow-up visit, the review of test results ordered at an earlier encounter is not counted again because the ordering at the previous visit already included that credit. However, if the provider receives and reviews radiology or laboratory reports from another clinician, the review of those outside results can be counted toward MDM.

4. **Number and Complexity of Problems Addressed at the Encounter:** CPT® E/M Service Guidelines defines *Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.* These are conditions that can heal on their own not involving any follow-up or treatment that needs to be given by the provider.

5. **Reporting Bronchitis vs Acute Bronchitis:** When the final diagnosis is documented simply as bronchitis, you should report J40. Do not assign J20.9 unless the provider specifically documents that the bronchitis is acute. Without the term "acute" the correct code is the unspecified bronchitis code, J40.

6. **Consultation Rules:** Consultations, according to CPT® coding guidelines, require: 1. A request by a physician or other qualified source; 2. That the service is to recommend care for a specific condition or problem, or to determine whether to accept responsibility for ongoing management of the patient's entire care or specific condition; and 3. A written report back to the requesting provider. If all three conditions are not met (for example, there is no documentation of a written report back to the referring provider), a consultation cannot be coded. CMS no longer reimburses consultations; you are directed to code office and outpatient codes or hospital care codes when the case note indicates it is a Medicare patient. Do not assume the patient is covered by Medicare based on age. On the exam, if Medicare covers the patient, the information is provided in the case note or the question.

7. **Modifier 25:** The use of this modifier does **not** require two different diagnoses. For example, if a physician or other qualified healthcare professional evaluates a new problem or medical condition and determines that an immediate in-office procedure is necessary for treatment, the E/M service may be reported with modifier 25. When a procedure is 0- or 10-day global period, such as only applying a splint or repairing a laceration report modifier 25 on the E/M code.

8. **Application of a Splint:** When a provider performs definitive fracture care and also applies a splint, you should report only the fracture care code, as the splint application is included in the fracture treatment. The supply of the splint can be reported separately when the provider is paying for it.

9. **Inpatient Neonatal and Pediatric Critical Care:** When a critically ill neonate or pediatric patient is admitted, select from codes 99468, 99471, and 99475 based on the age of the child. For critical care subsequent visits, select from codes 99469, 99472, and 99476 based on the age of the child. Review the bundled services listed in the coding guidelines preceding codes 99291–99292 and 99468–99476. If the critically ill neonate or pediatric patient does not require inpatient admission, report the critical care based on time using 99291–99292.

10. **Pediatric Critical Care Patient Transport:** Codes 99466–99467 are reported by the provider who provides hands on care during an interfacility transport. For non-face-to-face direction of an interfacility transport team, report codes 99485–99486. The codes are selected based on time. Do not report 99466–99467 with 99485–99486 when performed by the same provider.

AAPC continuously evaluates and enhances our certification exams throughout the year. As AAPC continues to enhance the certification exams, we are beta testing the inclusion of a fill-in-the-blank item type on our certification exams. To prepare you for both item types (multiple choice and fill-in-the-blank), we have provided two versions of this practice exam. The same questions are on both versions of the Test Your Knowledge practice exam; however, the last three cases on this version of the practice exam are fill-in-the-blank. If you prefer to test using the multiple-choice item type for all the cases, use practice exam B.

The following questions will test your comprehension of the information covered in this study guide. The answer key is used for both versions of the Test Your Knowledge practice exams.

Version A

CASE 1

Document Type: Paper documents.

Case Date: 05/20/20XX

Admission Date: 05/18/XX

Discharge Date: 05/20/20XX

D/C Summary: Pediatrics well newborn inpatient discharge note.

Interval History: Born in the hospital via cesarean delivery. Baby did well overnight. Fed better, mother now more comfortable. Voiding and stooling well. Primary Care Provider: EGA: 41/1 Birth Weight: 3.855 kg (70%) Discharge Weight: 3.64 kg, decrease of 5.6% Time of Birth: 18:02 on 5/18/XX LRCM: 1 hr 57 min Mode of Delivery: Cesarean Apgar: 9/9 Feeding: Breast milk Transcutaneous Bilirubin: 2.2 at 16 hours of life for low risk Infant female born to a 33-year-old G8 P2->3 mother with blood type AB pos, AB screen neg, GBS neg, Hepatitis B surface Ag neg, Rubella Immune, VDRL Non-reactive, Chlamydia neg, GC neg, and HIV neg. Complications of delivery include: Meconium noted on delivery record with initial SROM of clear fluid. Pediatrics not present. No interventions required.

Maternal Past Medical and Pregnancy History: History of hip dislocation, multiple SABs, and thalassemia to the pregnancy. Course was complicated by spotting through second trimester and therapeutic ultrasound for hip dislocation at 5 months' gestation. Medications during the pregnancy included PNV and Fe Sulfate. Mother denies tobacco, alcohol, and drug use.

Social History: Infant is to live with mother, father, and 2 older sisters. There is no smoking in the home.

Family History: Positive for maternal aunt, sister, and cousins with jaundice, none requiring therapy. One female cousin died less than 40 days of life, cause unknown. Oldest sister with amblyopia, now resolved. Paternal cousin with cognitive and speech delay. Two other paternal cousins with progressive night blindness, parents are consanguineous first cousins. No other significant diseases of infancy or childhood. MGF with HTN and macular degeneration, MGM and MMGM with anemia—likely thalassemia. PGM with DMII, PGF with HTN, manic depression but died at 65 from stroke. Father with migraines, depression (attempted medication but symptoms worsened), and hepatitis C on interferon treatment.

Physical Exam: Length: 56.0 cm (>97%). Head Circumference: 35.0 cm (50%). Pulse Ox: 100% on room air. General: Well-appearing newborn in no apparent distress. Head: Anterior fontanelle open, flat and soft, no significant molding, caput or cephalohematoma. ENT: Intact palate, mucous membranes moist, normal set ears, nares. Neck: No masses, intact clavicles. Cardiac: Regular rate and rhythm w/normal femoral pulses 2+ bilaterally, normal S1/S2 and no murmurs, without erythema or hepatosplenomegaly or masses, normal respiratory rate, no respiratory distress. Abdomen: Soft, nontender, nondistended, umbilicus, normal bowel sounds. Eyes: Bilateral red reflex, clear and non-icteric conjunctivae, to light. Patent pupils equal,

round, and reactive, drainage. Extremities: Normal Ortolani and Barlow, symmetric movements; 10 fingers and 10 toes. Genitalia/Anus: Patent anus, normal. Tanner I female Neurologic: Normal tone and reflexes present. Spine: Straight, no hair tufts or sacral dimples. Skin: No significant rashes, lesions or jaundice, Dermal melanocytosis on buttocks, milia on nose and hard palate. Hospital Course: Vitamin K and erythromycin ointment given after delivery; Hepatitis B vaccine done 5/18/XX. Newborn screen after 24 hrs of life drawn 5/19 BAERS done 5/19/XX, passed bilaterally.

Assessment: Baby girl is a healthy term infant girl.

Plan: 1) Family received discharge instructions and written materials. 2) Feeding issues: Improved feeding overnight was given from nursing and lactation team. Appreciate input. 3) Discharge home following 24 hr observation for cesarean delivery with first visit to pediatrician 1-3 days following discharge. I was physically present for the E/M service provided.

I agree with House Officer's note and plan which I have reviewed and edited where appropriate. I was physically present for the key portions of the service provided. Discharge day only: Total time spent: 45 minutes.

1. What is the E/M code?

   A. 99238
   B. 99239
   C. 99234
   D. 99221

2. What is the ICD-10-CM diagnosis code?

   A. Z00.121
   B. Z38.01
   C. Z00.110
   D. Z00.00

CASE 2

CC: Established patient complains of having headaches. School nurse told him he had wax in his ears. Not sure of frequency but strong and painful for more than two weeks. Also complaining of being tired.

Denies: Fatigue or fever; SOB; Constipation or diarrhea

Current meds: Zyprexa 7.5, Lithium 450

Allergies: NKDA

PFSH: No changes.

WT: 116 TEMP: 99.2

Exam:

Appears healthy and well developed. Head and face are normal on inspection. Eyes: Gross visual field testing by confrontation. No abnormalities indicated. ENMT: Tympanic membranes translucent, with good landmarks bilaterally. Impacted wax in canals bilaterally. Nasal mucosa: Pink and moist. Septum: Midline. Nasopharynx: Normal to inspection. Dentition: Good repair. Oral Mucosa: Moist with no thrash/no mucositis. Tongue: Appears normal. Posterior Pharynx: Normal. Tonsils: Appear normally colored and ovoid. Neck: Palpation reveals no cervical nodules. Thyroid: Normal to palpation. Respiratory: Lungs: clear anteriorly, posteriorly, laterally.

CPEDC™ Practice Examination –Answer Key and Rationales

After reviewing the answers and rationales, if you have further questions, please send them to: mct@aapc.com

CASE 1

Document Type: Paper documents.

Case Date: 05/20/20XX

Admission Date: 05/18/XX

Discharge Date: 05/20/20XX

D/C Summary: Pediatrics well newborn inpatient discharge note. [1]

Interval History: Born in the hospital via cesarean delivery. Baby did well overnight. Fed better, mother now more comfortable. Voiding and stooling well. Primary Care Provider: EGA: 41/1 Birth Weight: 3.855 kg (70%) Discharge Weight: 3.64 kg, decrease of 5.6% Time of Birth: 18:02 on 5/18/XX LRCM: 1 hr 57 min Mode of Delivery: Cesarean Apgar: 9/9 Feeding: Breast milk Transcutaneous Bilirubin: 2.2 at 16 hours of life for low risk Infant female born to a 33-year-old G8 P2->3 mother with blood type AB pos, AB screen neg, GBS neg, Hepatitis B surface Ag neg, Rubella Immune, VDRL Non-reactive, Chlamydia neg, GC neg, and HIV neg. Complications of delivery include: Meconium noted on delivery record with initial SROM of clear fluid. Pediatrics not present. No interventions required.

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Assessment: Baby girl is a healthy term infant girl. [2]

Plan: 1) Family received discharge instructions and written materials. 2) Feeding issues: Improved feeding overnight was given from nursing and lactation team. Appreciate input. 3) Discharge home following 24 hr observation for cesarean delivery with

first visit to pediatrician 1-3 days following discharge. I was physically present for the E/M service provided. I agree with the House Officer's note and plan which I have reviewed and edited where appropriate. I was physically present for the key portions of the service provided. Discharge day only: Total time spent: 45 minutes. [3]

[1] Indication patient is in the hospital ready to be discharged.

[2] Primary diagnosis.

[3] Time documented for the discharge.

1. **Answer:** B. 99239

   Rationale: The patient is being discharged from the hospital. The discharge codes are selected based on time. The provider documents that he spent 45 minutes discharging the patient. The correct code is 99239.

2. **Answer:** B. Z38.01

   Rationale: ICD-10-CM Official Coding Guidelines for Coding and Reporting, I.C.16.a.2, tell us: "When coding the birth episode in a newborn record, assign a code from category Z38, *Liveborn infants* according to place of birth and type of delivery, as the principal diagnosis. A code from category Z38 is assigned only once, to a newborn at the time of birth. If a newborn is transferred to another institution, a code from category Z38 should not be used at the receiving hospital." A code from category code Z38 is used for the entire birth stay in the hospital of birth and should remain in effect up until the discharge.

CASE 2

CC: Established patient complains of having headaches [1]. School nurse told him he had wax in his ears. Not sure of frequency but strong and painful for more than two weeks. Also complaining of being tired.

Denies: Fatigue or fever; SOB; Constipation or diarrhea

Current meds: Zyprexa 7.5, Lithium 450

Allergies: NKDA

PFSH: No changes.

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Exam::

Appears healthy and well developed. Head and face are normal on inspection. Eyes: Gross visual field testing by confrontation. No abnormalities indicated. ENMT: Tympanic membranes translucent, with good landmarks bilaterally. Impacted wax in canals bilaterally. Nasal mucosa: Pink and moist. Septum: Midline. Nasopharynx: Normal to inspection. Dentition: Good repair. Oral Mucosa: Moist with no thrash/no mucositis. Tongue: Appears normal. Posterior Pharynx: Normal. Tonsils: Appear normally colored and ovoid. Neck: Palpation reveals no cervical nodules. Thyroid: Normal to palpation. Respiratory: Lungs: clear anteriorly, posteriorly, laterally.

Impression: Impacted cerumen and headaches [2]

Plan: Cerumen: Deeply impacted in both ears and required use of curettes and suction for removal [3]. Need to watch and monitor for migraines. Will observe for now and patient will quantify.

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