PAY ATTENTION TO BILLING, CODING

To the editor:

Dr. Traisman’s article on pediatric coding [Pediatric coding: what you need to know to enhance your clinical practice’s reimbursement process. Pediatric Ann. 2010;39(6):362-366] was informative and well written. Dr. Traisman accurately details the six sections of the current procedural terminology (CPT) book and goes on to state that, “for the pediatrician, the important aspects of CPT coding are the E/M, Pathology and Laboratory, and Medicine sections.” Although these three sections are vitally pertinent and important to the practicing pediatrician, any pediatrician who does not make use of the codes in the Surgery section is depriving himself of income.

Many procedures commonly performed by pediatricians can be found in the Surgery section of the CPT book. For example, removal of a bead from a child’s nose is a procedure found in the ENT section, and reducing the subluxation of the radial head (nursemaid’s elbow) can be found in the Orthopedic section. Suturing the skin, removing cerumen from the ears, and performing a pulmonary function test are all procedures that have codes that can be found in different sections of the CPT book. Any physician can use any CPT code, but you must remember to document the services rendered in order to justify the codes selected. Procedures usually have higher RVU (relative value units) assigned to them as compared with E/M codes. To be paid for the procedures you perform, you must code for them.

Dr. Traisman also mentions the use of time in deciding which level of E/M coding to use. He states that, “if more than 50% of time spent … is devoted to coordinating care and/or counseling … then it affects E/M services.” Although it is true that time can be used as a factor in determining which level of coding to use, it must be used appropriately. For example, if a child presents in the office with a rash, the proper code to use would be 99212. If, during the visit, the parent initiates a discussion about their patient’s enuresis, and the pediatrician spends greater than 50% of the visit time counseling the parents, then it is advantageous to use time to decide which code to use. Use 99212 for 10 minutes of your time, 99213 for 15 minutes, 99214 for 25 minutes, and 99215 for 40 minutes. These rates are all specific to established patients. When seeing new patients, use codes 99201-5, but understand that these codes require more time. If you spent 5 minutes treating the child’s rash and an additional 10 minutes was spent counseling the parents on the enuresis, you would still use the 99213 code.

Document the actual time spent (9 a.m. to 9:15 a.m.), and record that more than 50% of the time was spent counseling. On the other hand, if the patient comes in only for enuresis counseling, there is no physical and you spent 15 minutes discussing the problem, you would still use the 99213 code but you do not have to use the more than 50% wording, just the actual time.

Dr. Traisman does a great job defining the pediatrician’s most important modifier, the -25 modifier, but, in my opinion, its use in his example is incorrect. The patient described has impetigo and an abscess that requires drainage. The -25 modifier was placed on the procedure code 10060. American Academy of Pediatrics CPT coders teach that the -25 modifier goes on the E/M visit not on the procedure code. Some insurance carriers do not require the -25 modifier on the E/M, but they do require the modifier -59 for a distinct procedural service to go onto the 10060 code. If a particular insurance carrier requires that you code something their way rather than using standard CPT coding, ask for confirmation in writing. It is important to understand the proper usage of modifiers. There are other important modifiers that pediatricians should be using; -76, -77, and -22 are just a few.

As Dr. Traisman asserts, billing has become very complex. Some offices employ billing services to help navigate the billing terrain. I would urge pediatricians to do their homework before selecting a billing service. These services charge pe-
HYDRATION PRACTICES FOR YOUNG ATHLETES QUESTIONED

To the editor:

I read with interest a recent article on hydration recommendations for pediatric athletes [Sports nutrition in young athletes. Pediatr Ann. 2010;39(5):300-306]. This letter attempts to rectify the author’s recommendations with published scientific data on the topic of hydration during exercise.

Fluid needs per kilogram are, indeed, increased for pediatric patients when compared with adults because children have a larger percentage of total body water (TBW) than do older patients. I am unaware of published data that indicate deficiency in the pediatric thirst mechanism of otherwise healthy individuals.

Newborns with congenital nephrogenic diabetes insipidus exhibit water craving behaviors and can maintain euhydration if given sufficient access to water, arguing that in fact children have fully developed central thirst mechanisms to protect plasma osmolality (Posm).1 In healthy children, normal Posm is approximately 280 to 290 mOsm/L, which is just above the average threshold for basal arginine vasopressin (AVP) secretion and below the thirst threshold.

Those that state that “thirst is too late” to begin fluid repletion ignore the fact that physiological mechanisms to conserve water and concentrate urine have already begun by the time the thirst threshold is reached. Strict fluid guidelines and hydration prescriptions encourage children to overhydrate.

Sweat losses per kilogram in children are increased due to the child’s larger surface-area-to-volume ratio. Coaches and activity directors must be aware of this and offer frequent hydration breaks during exercise, especially during warm and hot environments when volume loss to sweat will be increased. There is data to indicate that 2% dehydration in children is sufficient to produce a decrease in cognition.2 There exists considerable controversy as to the dangerous effects of mild dehydration during exercise.3 Although nonsickle-cell-related deaths due solely to dehydration during exercise have not been reported, numerous cases in the literature support overhydration and subsequent hyponatremia as a cause of death.5,7

Measurement of hydration status is problematic in children as well as adults. There exists no single standard to measure TBW outside of tightly controlled laboratory conditions,6 due primarily to its complex and dynamic hormonal regulation. Pre- and post-event weighing is likely more able to identify overhydration, indicated by weight gain, than dehydration. It has been demonstrated that endurance athletes may lose up to 4% to 5% of body weight without a drop in TBW as measured by changes in total body water (TBW); this calls into question the validity of recommendations to replace fluid volumes equal to weight loss during exercise.

Multiple authors have found urinary assessment to be a poor predictor of TBW and hydration status.11-13 The author’s assertion that “Morning void should be light in color and copious” is likely to promote overdrinking and is especially problematic, given that children...
may sleep 10 or more hours nightly and usually do not hydrate nocturnally. It is unclear which physiological mechanisms would promote a hypotonic diuresis under such conditions of relative fluid restriction.

In exercise lasting greater than 1 hour, it is generally agreed that carbohydrate-electrolyte solutions (CES), also known as sports drinks, that contain approximately 6% CHO and 18 mmol/L sodium may benefit athletes. The benefit derived from these beverages is twofold. First, the combination of solute makes most CES slightly hyperosmolar to blood. The resultant rise in Posm stimulates the thirst mechanism, which may stimulate drinking and hasten rehydration.14 Second, calories from ingestion of CES slightly hyperosmolar to blood. The resultant rise in Posm stimulates the thirst mechanism, which may stimulate drinking and hasten rehydration.14

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Therefore, despite marketing efforts to convince us otherwise, “sodium and electrolyte replacement” are not required in healthy young athletes.

Given the data presented, it is incumbent upon parents, coaches, and those monitoring exercise in pediatric patients not to rely on universal recommendations17 but to give frequent access to appropriate fluids and encourage exercising children to drink when they are thirsty. This biological mechanism has been shown to avoid the dangers of overhydration, as well as effects of excessive dehydration, and is the safest choice for children who exercise.

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REFERENCES

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