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In This Issue

AAP Pediatric Coding Newsletter™ Electronic Pages (See page 8.)

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American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

The 2007 Resource-Based Relative Value Scale

The Centers for Medicare & Medicaid Services published the 2007 Medicare Resource-Based Relative Value Scale (RBRVS) in the Federal Register *on December 1, 2006. You can access it on the CMS Web site at www.cms.hhs.gov/PhysicianFeeSched/.*

Why are these Medicare relative value units (RVUs) so important to your practice? Many state Medicaid programs and other third-party payers use the Medicare RVUs to establish their own payment policies. However, some payers do not use the Medicare RVUs and will establish their own relative values. It is extremely important that each practice understand the basis a payer uses to determine its payment rates.

Using RBRVS

The total RVU for a given *Current Procedural Terminology (CPT®)* code is the total of all the associated work and expenses (practice and malpractice expenses) based on the national average relative costs. For most codes, practice expenses are established for both facility (eg, hospital) and non-facility (eg, office) settings.

A geographic practice cost index (GPCI) is assigned by Medicare to reflect the relative costs associated with physician work, practice expenses, and malpractice expenses in each Medicare locality. A Medicare conversion factor (CF) is then established and used to convert the RVUs into payments for Medicare services. The 2007 Medicare CF is $**37.8975,** the same as last year.

To calculate the Medicare payment rate, multiply the total geographically adjusted RVU (RVUs for physician work, facility or non-facility practice expense, and malpractice expense multiplied by the GPCI for your area or locality) by the Medicare CF.

To calculate the non-Medicare payment rate, multiply the total RVU (physician work, facility or non-facility expense, malpractice expense) by a payer-specific or practice CF. (Most payers, including state Medicaid programs, will establish their own CF.)

(continued on page 2)

The 2007 Resource-Based Relative Value Scale

(continued from page 1)

The New Medicare Relative Values for 2007

The Table provides you with the Medicare relative values for some of the new and revised 2007 *CPT* codes. As reported in the November 2006 (Vol 2, No. 2) issue of *Pediatric Coding Companion*™, revisions have been made to many of the physician work RVUs for 2007. Therefore, the revised relative values for some evaluation and management services have also been provided. You can access the complete list of RVUs and the GPCIs for your area at www.cms.hhs.gov/apps/pfslookup. You may also find an updated list of the most commonly performed pediatric procedures with the associated RVUs at www.aap.org/visit/RBRVSbrochure.pdf.

2007 Medicare Relative Value Units

CPT Code	Descriptor	Work RVU	Non-facility Practice Expense RVU	Facility Practice Expense RVU	Malpractice RVU	Total Non-facility RVUs/$	Total Facility RVUs/$
	New Patient						
	Office/Outpatient Visits						
99201	Problem-focused history and exam/ straightforward	0.45	0.51	0.15	0.03	0.99/$37.52	0.63/$23.88
99202	Expanded problem-focused history and exam/straightforward	0.88	0.80	0.31	0.05	1.73/$65.56	1.24/$46.99
99203	Detailed history and exam/low complexity	1.34	1.13	0.47	0.09	2.56/$97.02	1.90/$72.01
99204	Comprehensive history and exam/ moderate complexity	2.30	1.50	0.71	0.12	3.92/$148.56	3.13/$118.62
	Established Patient						
	Office/Outpatient Visits						
99213	Expanded problem-focused history and exam/low complexity	0.92	0.71	0.25	0.03	1.66/$62.91	1.20/$45.48
99214	Detailed history and exam/moderate complexity	1.42	1.05	0.42	0.05	2.52/$95.50	1.89/$71.63
99215	Comprehensive history and exam/high complexity	2.00	1.34	0.64	0.08	3.42/$129.61	2.72/$103.08
	Circumcision						
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block; newborn	**1.90**	**1.50**	**1.09**	**.16**	**3.56/$134.92**	**3.15/$119.38**
54160	Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate	**2.50**	**4.03**	**1.19**	**.19**	**6.72/$254.67**	**3.88/$147.04**
54161	Circumcision, surgical excision other than clamp, device, or dorsal slit; except newborn	**3.29**	**NA**	**1.73**	**.23**	**NA**	**5.25/$198.96**
	Surfactant Administration						
94610	Intrapulmonary surfactant administration by a physician through endotracheal tube	**1.16**	**.35**	**.35**	**.26**	**1.77/$67.08**	**1.77/$63.69**

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2007 Medicare Relative Value Units

CPT Code	Descriptor	Work RVU	Non-facility Practice Expense RVU	Facility Practice Expense RVU	Malpractice RVU	Total Non-facility RVUs/$	Total Facility RVUs/$
	Home Apnea Monitoring						
94774	Pediatric home apnea monitoring event recording including respiratory rate, pattern, and heart rate per 30-day period; includes monitor attachment, download of data, physician review and interpretation, and preparation of a report	0	0	0	0	0	0
94777	Physician review, interpretation, and preparation of report only	0	0	0	0	0	0
	Home Ventilator Management						
94005	Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary, or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies, and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more	1.50	.69	NA	.06	2.25/$85.27	NA
94002	Ventilation assist and management, initiation of pressure or volume-preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day	1.99	NA	.34	.09	NA	2.42/$91.71
94003	Hospital inpatient/observation, each subsequent day	1.37	NA	.33	.06	NA	1.76/$66.70
94004	Nursing facility, per day	1.00	NA	.24	.04	NA	1.28/$48.51
	Continuous Inhalation Treatment						
94644	Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour	0	.92	NA	.02	.94/$35.62	NA
94645	Each additional hour	0	.34	NA	.02	.36/$13.64	NA
	Nitric Oxide Test						
95012	Nitric oxide expired gas determination	0	.48	NA	.01	.49/$18.57	NA
	Intravenous Infusions						
90760	Intravenous infusion, hydration; initial, up to 1 hour	.17	1.40	NA	.07	1.64/$62.15	NA
90761	Each additional hour	.09	.38	NA	.04	.51/$19.33	NA
	Medical Genetics and Genetic Counseling Services						
96040	Medical genetics and genetic counseling services, each 30 minutes face to face with patient/family	0	.97	NA	.01	.98/$37.14	NA
	Destruction Benign or Premalignant Lesions						
17000	Destruction premalignant lesions; first lesion	.62	1.08	.59	.03	1.73/$65.56	1.24/$46.99
17003	Second through 14 lesions, each	.07	.11	.06	.01	.19/$7.20	.14/$5.31
17004	Destruction premalignant lesions, 15 or more lesions	1.82	2.33	1.54	.11	4.26/$161.44	3.47/$131.50
17110	Destruction of benign lesions other than skin tags or cutaneous vascular lesions, up to 14 lesions	.67	1.66	.74	.05	2.38/$90.20	1.46/$55.33
17111	15 or more lesions	.94	1.83	.89	.05	2.82/$106.87	1.88/$71.25

Coding for Emergency Department Visits

Current Procedural Terminology (CPT®) codes **99281–99285** are used to report evaluation and management (E/M) services provided in the emergency department (ED). *CPT* defines an ED as "an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day."

This definition clearly precludes the use of codes **99281–99285** when E/M services are performed in an urgent care center or any freestanding facility that is not hospital-based or open for 24 hours a day. Services performed in those settings must be reported with *CPT* codes **99201– 99205** (office/outpatient E/M services) because they do not meet the *CPT* definition of an ED.

Who Uses These Codes?

The use of the ED E/M codes is not exclusive to ED physicians (ie, primary ED staff physician). However, there are caveats in that only one physician can report the ED codes for any single ED patient visit. The following examples demonstrate how the services should be reported when 2 physicians provide services for a single ED patient visit.

1. An office-based physician asks a patient to meet him or her at the ED for care. The ED physician does not treat the patient. The attending office-based physician would report the ED E/M codes based on the level of service provided and documented.
2. A patient is seen by the ED physician, who decides to transfer the care of the patient to another physician. The ED physician (Physician A) will report the ED E/M code and the physician assuming the care of the patient (Physician B) will report an office or outpatient E/M code **(99201–99215).** If the patient is admitted by Physician B during the course of the visit, the initial observation **(99218–99220)** or initial hospital care **(99221–99222)** codes will be alternatively reported. (If the patient is admitted and discharged on the same day of service, codes **99234–99236** would be alternatively reported). The level of service reported for the admission is based on all of the E/M services provided by the admitting physician during the course of the day. Remember that *CPT* guidelines specify that when a patient is admitted to the hospital (either inpatient or observation status) in the course of an encounter in another site of service (eg, hospital ED), all E/M services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date of service.
3. The ED physician (Physician A) requests a consultation from another physician (Physician B). The ED physician (Physician A) will report the appropriate-level ED code and the consulting physician (Physician B) will report the consultation using the office or other outpatient consultation codes **(99241–99245).** If Physician B admits the patient from the ED, only the initial hospital care code **(99221–99223)** will be reported. If Physician B makes the decision to perform surgery, modifier **57** should be appended to the reported E/M code.
4. A patient meets his physician (Physician A) at the ED. A second physician (Physician B) treats the patient at the request of Physician A. Physician B will report his services as a consultation (if the requirements for reporting a consultation are met) or as an office or outpatient E/M service. Physician A will report the appropriate ED service.
5. A patient is seen in the ED by Physician A. Physician A admits the patient to observation. Only the initial observation **(99218–99220)** service will be reported based on the level of care provided by Physician A in the ED and as part of the initial observation care. Or, the ED physician writes "holding" admission orders for a patient being admitted under another physician's service. The admitting physician will then report only the initial observation care **(99218–99220).**

***Tip:* All services provided in the ED should be reported with place of service code 23.**

Selecting the Appropriate Level of Service

The performance and documentation of all 3 *key* components (history, physical examination, and medical decision-making) are used to select the level of an ED E/M code. Three additional components (counseling, coordination of care, and the nature of the presenting problem) are contributory factors and are not required for the selection of a code. *CPT* has not assigned any average or typical time to this family of codes because of the unpredictability and inconsistency in the intensity of the service. Therefore, time cannot be used as a key or controlling factor in the selection of the code.

Note that the description of service for *CPT* code **99285** states that use of this code requires the performance of the "three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status." This means that code **99285** may be reported if the patient's condition requires a comprehensive history and physical examination but circumstances prevent the

physician from obtaining a comprehensive history and/or completing a comprehensive physical examination. (In addition, the patient's condition would require a high level of medical decision-making.)

Tip: **The medical record documentation must state the reason that a comprehensive history and/or physical examination were unable to be performed.**

The Table on page 7 summarizes the key components required for each ED E/M code based on the 1995 and 1997 Centers for Medicare & Medicaid Services (CMS) Documentation Guidelines for E/M Services. Note that there is no distinction between new or established patients.

Tip: **Physicians may use either the 1995 or 1997 CMS Documentation Guidelines. Most physicians find the 1995 guidelines easier to follow, while some specialists may find the 1997 guidelines to be more applicable. Note that *CPT* guidelines for a comprehensive examination differ from the 1995 CMS Documentation Guidelines in that there is no limit to the number of systems required for a multisystem examination. Most payers, including state Medicaid programs, rely on the 1995 or 1997 CMS Documentation Guidelines. You can access both sets of guidelines at www.cms.hhs.gov/MedlearnProducts/20_DocGuide.asp.**

Can Critical Care Be Reported When Performed in the ED?

Critical care services (**99291–99292**) can be reported when performed in the ED if the care of the critically ill or injured patient is based on the *CPT* definition of critical care. Critical care and an ED visit may be reported by the same physician when performed on the same day of service. However, there must be 2 distinct services provided. If only critical care services are provided, codes **99291** (critical care, first 30–74 minutes) and **99292** (each additional 30 minutes) are reported based on the total time the physician spends in the provision of the critical care services. The neonatal and pediatric critical care services (**99293–99296**) cannot be reported because they are restricted to inpatients only. The critical care services are reported based on the total time spent face to face with the patient or time spent performing work directly related to the patient's care. Remember that critical care codes are bundled services and include many procedures. The time spent performing any procedures that are not bundled (and therefore are billable) with the critical care service codes must be excluded from the time spent providing critical care.

For example, an infant presents to the ED after being found in the family's pool. The infant is not breathing and is intubated and resuscitated for 35 minutes. In this example, only codes **31500** (endotracheal intubation) and **92950** (cardiopulmonary resuscitation [CPR]) would be reported because both procedures are not bundled and cannot be counted as critical care time. However, if critical care services are provided for 30 minutes before the infant requires resuscitation, the procedures may be reported in addition to the critical care (**99291**). What if CPR was performed for 10 minutes and the infant was stabilized and sent to the intensive care unit (ICU) 25 minutes later? In this situation an ED visit (**99285**), intubation (**31500**), and CPR (**92950**) would be reported. Critical care services would not be reported in this case because less than 30 minutes was spent providing critical care.

Consider this example of when both an ED visit and critical care might be reported. A child is seen for injuries following an automobile accident. A comprehensive history and physical examination are performed. While under observation and waiting for radiology, the child goes into respiratory arrest. Critical care is then initiated and continues for 45 minutes. In this example, both an E/M service (**99285**) and critical care (**99291**) were provided. Any procedures that are not bundled with critical care would also be reported and the time spent in performing them would be deducted from the total critical care time. Conversely, if critical care is provided for 30 or more minutes and the patient then stabilizes and does not require critical care, an ED E/M service may be reported if a significant, separately identifiable service is performed and documented.

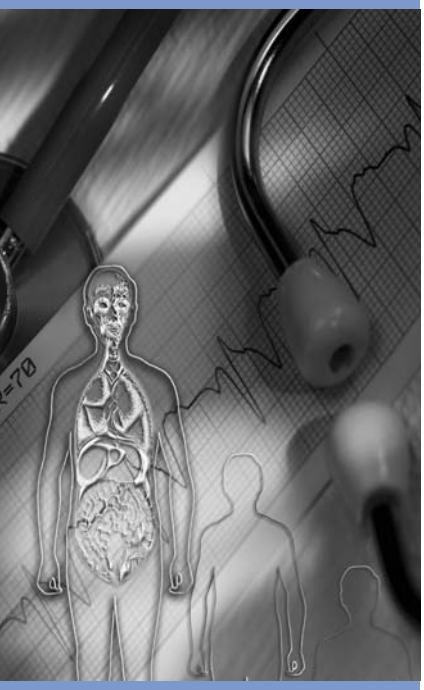
Tip: **Critical care is considered to be an E/M service. Therefore, when a procedure or service is performed on the same day, modifier 25 should be appended to the critical care codes.**

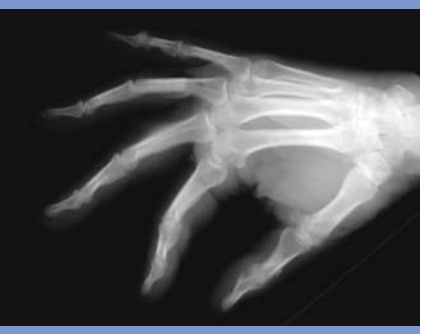
Reporting Procedures

Procedures performed by the physician can be reported in addition to the ED E/M service. Because ED services are provided in a hospital facility, services performed by hospital staff are reported by the facility and not by the ED physician. (They are not considered incident-to services.) For example, the ED physician would not report a routine venipuncture

(continued on page 7)

Q&A





May we report moderate sedation services provided by a physician other than the health care professional performing insertion of a tunneled centrally inserted central venous catheter without a subcutaneous port or pump in a 12-year-old child when the procedure is performed in an outpatient department (99148– 99150)? Procedure code 36558 is included in Appendix G of the *Current Procedural Terminology (CPT®)* manual.

Because guidelines for reporting codes **99148–99150** seem to be somewhat confusing, we sought clarification from the American Medical Association's (AMA) *CPT* Editorial Research and Development Department. Following is a summary of the *CPT* guidelines for codes **99148–99150** followed by the response from the AMA.

Codes **99148–99150** are reported by a second physician who provides moderate sedation to a patient in the facility setting (eg, hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility) while another physician performs the procedure or diagnostic study. In this case, the second physician acts as the "independent trained observer." These services can be reported with procedures identified in Appendix G *when they are performed in a facility* setting by another physician (other than the health care professional who is performing the procedure or study) in cases requiring a higher intensity of work than normal. The use of codes **99148–99150** is not appropriate when performed with procedures listed in Appendix G in a non-facility setting (eg, **36558**) because most procedures identified in Appendix G are usually performed in a hospital or ambulatory surgical center, and the procedures identified in Appendix G have the provision of moderate sedation included in them.

To clarify, *CPT* has no restriction in the moderate sedation section guidelines that restricts the use of codes **99143–99150** with procedures not listed in Appendix G. The Table will assist in the reporting of these services.

The December 2006 (Vol 1, No. 15) issue of *Pediatric Coding Companion*™ featured coding for moderate (conscious) sedation services (**99143–99145** and **99148–99150**).

Codes for Reporting Conscious Sedation

Codes	May Report 99143–99145	May Report 99143–99145	May Report 99148–99150	May Report 99148–99150
	Facility	Non-facility	Facility	Non-facility
Appendix G	No	No	Yes	No
All other *CPT* codes	Yes	Yes	Yes	Yes

Coding for Emergency Department Visits

(continued from page 5)

Emergency Department Visits Based on 1995 and 1997 Guidelines*

New/ Established Patient	Medical Decision-Making	History†	Physical Examination
99281	Straightforward—meets 2 of 3 Diagnoses/options—minimal Data—minimal Risk—minimal	HPI—Brief, 1–3 elements ROS—0 PFSH—0	Problem focused **1995**—1 body area/organ system **1997**—Performance and documentation of 1–5 elements identified by a bullet (●) in ≥1 area(s) or system(s).
99282	Low complexity—meets 2 of 3 Diagnoses/options—limited Data—limited Risk—low	HPI—Brief, 1–3 elements ROS—1 PFSH—0	Expanded **1995**—Limited exam of affected body area/organ system and other related areas/systems. **1997**—Performance and documentation of at least 6 elements identified by a bullet (●) in ≥1 area(s) or system(s).
99283	Moderate complexity—meets 2 of 3 Diagnoses/options—multiple Data—moderate Risk—moderate	HPI—Brief, 1–3 elements ROS—1 PFSH—0	Expanded **1995**—Limited exam of affected body area/organ system and other related areas/systems. **1997**—Performance and documentation of at least 6 elements identified by a bullet (●) in ≥1 area(s) or system(s).
99284	Moderate complexity—meets 2 of 3 Diagnoses/options—multiple Data—moderate Risk—moderate	**1995** HPI—Extended, 4+ elements ROS—2–9 PFSH—1 **1997** HPI—Extended, 4+ elements or status of 3 chronic or inactive conditions ROS—2–9 PFSH—1	Detailed **1995**—Extended exam of affected body area(s) and other symptomatic or related organ system(s). **1997**—Performance and documentation of at least 2 elements identified by a bullet (●) in at least 6 areas or systems or at least 12 elements identified by a bullet (●) in at least 2 areas or systems.
99285	High complexity—meets 2 of 3 Diagnoses/options—extensive Data—extensive Risk—high	**1995** HPI—Extended, 4+ elements ROS—10+ PFSH—2 **1997** HPI—Extended, 4+ elements or status of 3 chronic or inactive conditions ROS—10+ PFSH—2	Comprehensive **1995**—8+ organ systems or complete exam of a single organ system. **1997**—Multisystem exam—Exam of at least 9 organ systems or body areas with performance of all elements identified by a bullet (●) in each area/system examined. Documentation is expected for at least 2 elements identified by a bullet (●) in each area(s) or system(s). Single organ system exam—performance of all elements identified by a bullet (●) and documentation of every element in each box with a shaded border and at least 1 element in a box with unshaded border.

*Three of 3 key components must be met.
†HPI, history of present illness; ROS, review of systems; PFSH, past family and social history.

(36415). However, if the venipuncture required the physician's skill, codes **36400–36410** would be reported by the physician.

Examples of some of the procedures that are routinely performed in the ED include burn care, intubation, incision and drainage of abscesses, insertion of chest tubes, and resuscitation.

Third-party payer policies may guide billing for certain procedures. It is common for the ED physician to repair lacerations and refer the patient to his or her primary care physician for removal of the sutures. Although laceration repair is considered part of the *CPT* surgical package or Medicare global period, payers have recognized this practice and will typically reimburse the ED physician for the repair and another physician for the E/M visit required to remove the sutures. However, payment for more complex procedures is considered to be a bundled service inclusive of the preoperative care, surgical procedure, and associated postoperative care. For example, if the ED physician reports

(continued on page 8)

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Coding for Emergency Department Visits

(continued from page 7)

a fracture care code and sends the patient to an orthopaedic physician for all follow-up care, the payer may not make separate payment for the follow-up care because payment for the global service was made to the ED physician. There are several options for billing global surgery procedures performed in the ED. Using fracture care as an example, the following options can be used to bill global surgery services performed in the ED: (1) If the ED physician performs the fracture care and follow-up management, the fracture care code can be reported; (2) the ED physician can report the fracture care with modifier **54** (surgical care only) if he or she performs a significant portion of the global fracture care; or (3) the ED physician can report an ED E/M service and splinting (if performed personally by the physician), allowing the orthopaedic surgeon to report the fracture care.

Tip: **If billing the fracture care with modifier 54, the ED physician should coordinate billing with the orthopaedic physician. The orthopaedic physician then knows to report his or her services using modifier 55 (postoperative care only).**

Can the Special Services Codes Be Reported With the ED Codes?

The special services code that may be used by an ED physician (staff physician) in addition to the basic service(s) provided is *CPT* code **99053** (service[s] provided between 10:00 pm and 8:00 am at 24-hour facility, in addition to basic service). If appropriate, a non-ED physician could report *CPT* code **99056** (services[s] typically provided in office, provided out of office at request of patient, in addition to basic service) or **99060** (service[s] provided on an emergency basis, out of office, which disrupts other scheduled office services, in addition to basic service).

According to *CPT,* any physician of any specialty may report any procedure or service; however, payers will follow their individual policies for coverage and/or payment of these adjunct service codes.

AAP Launches Enhanced *AAP Pediatric Coding Newsletter™ Online* Web Site

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Additional content featured this month in the Electronic Pages includes

- Have You Noticed These 2007 *Current Procedural Terminology (CPT®)* Code Changes?

Tip for Current Users of the Web Site

You will now need your AAP account password to log in. Just click Sign In and you will be able to create a password if you have never had one, or submit a "forgot your password" request to have your password e-mailed to you.