



THE BUSINESS OF PEDIATRICS: CODING BASICS FOR SUCCESSFUL MEDICAL HOMES

16th CNHN Pediatric Practice Management Seminar
Wednesday, December 11, 2013



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Coding Basics for Successful Medical Homes



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Coding Basics: Update 2013

- New Codes for 2014
- Coding for Preventive Services
- E/M Coding
- Expanded Medical Home Services
- Extended hours
- Care Coordination
- Fraud & Abuse
- Resources

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New ICD Codes for 2014

- No new ICD-9-CM codes until “code freeze” removed in 2015
- New ICD-10 codes become effective October 1, 2014
- “Getting Ready for ICD-10” presentation later today

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New CPT Codes

- Released September 2013 by AMA
- Implementation January 1, 2014
- RVU's (relative value units) found on the CMS or AAP websites
- CMS
 - [www.CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html)
- AAP – RBRVS for Pediatricians 2013
 - <http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/RBRVS-What-Is-It-and-How-Does-It-Affect-Pediatrics.aspx>

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CPT- New for 2014

- Interprofessional Consultation- telephone or internet
- Complex Chronic Care Coordination- new language
- Transitional Care Management – new language
- Total Body Systemic or Selective Head Hypothermia
- Clarification Pediatric Critical Care Transport
- Removal of Impacted Cerumen
- Quadrivalent Influenza Vaccine
- Evaluation of Speech, Hearing & Language
- Anogenital examination
- Category 3 codes



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Interprofessional consultation

- The following four new time-based codes have been established to report telephone/Internet consultations:

• New for 2014 Code descriptor

- **99446** Interprofessional telephone/Internet 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



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Interprofessional consultation

- An **interprofessional telephone/Internet consultation** is a service where a physician or other qualified health care professional requests the opinion of a physician with specialty-specific expertise without a face-to-face encounter with the consulting physician. The services are typically provided in urgent situations where a face-to-face consultant may not be feasible, and the **appropriate code is reported by the consultant**.
- Key requirements to keep in mind:
 - Consultations of less than five minutes should not be reported
 - If the primary purpose of the communication is to arrange transfer of care, the codes should not be reported
 - The codes should not be reported by a consultant who has agreed to accept transfer of care *before* the telephone/Internet assessment
 - It is appropriate to report the codes if the decision to accept transfer of care cannot be made until *after* the initial interprofessional telephone/Internet consultation



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Removal of impacted cerumen

- **69210** Removal impacted cerumen (separate procedure) requiring instrumentation, 1 or both ears unilateral



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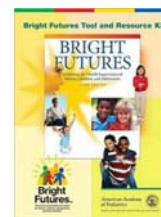
Quadrivalent influenza vaccine

- **90685** Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
- Joins new quadrivalent vaccines added in 2013
- Trivalent vaccine language added (90655-90660)



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Coding Pediatric Preventive Services



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ACA and Bright Futures

- As of Sept. 23, 2010, **Bright Futures and other preventive services, such as pediatric well-child visits—including a physical exam, immunizations, hearing and vision screening, developmental and behavioral screening, and anticipatory guidance—must be covered by new insurance plans without co-pays or deductibles** for families (No cost-sharing).
 - Bright Futures is the definitive standard of pediatric well-child and preventive care developed by an evidence-informed, active collaboration led by the AAP. In 2014, the law establishes state-based health insurance exchanges, allowing individuals and small businesses to compare and purchase health insurance online, among other places.
- All newly established plans in health insurance exchanges must provide comprehensive, essential benefits, including rehabilitative care, pediatric services, oral and vision services.



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Unexpected co-pays

- Families understand this no cost sharing and when they present for a PM service will NOT expect a bill or to pay a co-pay.
- However, many times non-preventive services will need to be performed at the same time.
- In order to pro-actively alleviate calls from parents, set up an office policy that outlines what is and what is not covered under PM services and thus what may incur cost-sharing.
 - Separate E/M services to address a significant acute or chronic problem-oriented issue
 - Procedures to deal with a problem
 - Note the AAP is working on a template.



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A suggestion for office message: "Understanding My Bill and Co-Pays"

- No co-pays are required for most preventive care services (or care provided to Medicaid-enrolled children.)
- Many times parents have extra concerns about their child's health or behavior that requires extra time and is not part of a routine preventive care visit.
- For the convenience of children and families, and when schedules permit, we try to address these added problems as part of your child's "check up" office visit.
- In this situation, as per guidelines developed by the AMA and American Academy of Pediatrics, we will bill for the added office visit time.
- Several insurance companies are now asking that we collect a co-pay from families when we address these extra problems in addition to the check-up visit.
- If more convenient, we can also schedule a separate appointment to address these additional health concerns.
- Our goal is to deliver the very best care to your child and family- comprehensive, convenient and fairly priced.
- If you ever have any questions about your bill, please feel free to speak with our billing manager (xxx). Your pediatrician is always available to answer questions about your child's care, health, diagnosis and bill.

Source: CNHN QI MOC Learning Collaborative



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Preventive Medicine Services

New Patient

- Initial E/M of a new patient including an age and gender appropriate history and exam, identification of risk factors, ordering of studies/labs, and anticipatory guidance
- 99381 Age < 1 year
- 99382 Ages 1 – 4 years
- 99383 Ages 5 – 11 years
- 99384 Ages 12 – 17 years
- 99385 Ages 18 – 39 years



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Preventive Medicine Services

Established Patient

- Periodic re-evaluation and management requiring an age and gender appropriate history and exam, identification of risk factors, ordering of studies/labs, and anticipatory guidance
- 99391 Age < 1
- 99392 Ages 1 – 4 years
- 99393 Ages 5 – 11 years
- 99394 Ages 12 – 17 years
- 99395 Ages 18 – 39 years



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Preventive Medicine Service

- Reflects an age- and gender-appropriate history and examination
- Is not synonymous with the comprehensive history and examination described in the CMS E/M guidelines for use with other E/M codes (eg, 99201-99215)
- Includes :
 - Age appropriate anticipatory guidance/Risk factor reduction
 - Age appropriate counseling
 - Review of vaccine history
 - Ordering of appropriate labs and diagnostic procedures
 - Developmental surveillance



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Preventive Medicine Service

- What they do not include
 - Individual vaccine (component) counseling
 - Administration of vaccines
 - Vaccine products
 - Screenings or other procedures with its own CPT code (eg, Vision screen, hearing screen, developmental screen)
 - Significant and separately identifiable E/M services to address an acute or chronic problem
 - Unrelated procedures (eg, wart removal)



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New Vs. Established

- A **new patient** is one who has not received any professional services (defined as face-to-face services reported with a CPT code) from a physician or any physician within the same group practice of the exact same specialty or subspecialty **within the past 3 years**
- An **established patient** is one who has received a professional service (defined as a face-to-face service reported with a CPT code) from a physician or any physician within the same group practice of the same specialty or subspecialty **within the past 3 years**



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Preventive Medicine and/or E/M

- What do you do if a significant illness or problem is found or needs to be addressed at a preventive medicine (PM) visit?
 1. Address both
 2. Have patient return for well-check



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Preventive Medicine and E/M

- Service should be above and beyond the other service provided and substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported
- Use Modifier 25: Defined as a "significant and separately identifiable E/M service by the same physician on the same day of the procedure or other service"
- If a significant problem/abnormality is found at a preventive medicine visit:
 - Code the appropriate "sick" E/M (99201-99215) visit in addition to 99381 – 99395
 - -Add modifier 25 to the "sick" E/M code
- If not significant and separate code only 99381 – 99395



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Modifier 25- Defining Key Terms

- Significant- must meet E/M Documentation guidelines
 - Would this have required a separate encounter anyway?
- Separately identifiable E/M service-
 - does it have key components above those of the PM service - Hx, Exam, and Medical Decision Making (MDM)
- Documentation
 - Suggest separate from the PM notes- but not required
 - Separate documentation makes correct EM code level selection easier- for the provider and for the auditor



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New Patient PM and E/M

- A 6-year-old presents to your office as a new patient for her preventive medicine service. During that encounter you perform a significant and separately identifiable E/M service to address a chronic medical problem
 - Preventive Medicine Service = New
 - E/M Service = New* (see next slide)



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New Patient – PM and E/M

- When a **new*** patient presents for a well-check, and you also evaluate a significant and separately identifiable problem (e.g. asthma), code both services as new per CPT guidelines. (use modifier 25)

- Note!!- the new patient (**9920x**) requires **3** of the **3** key components (Unless the criteria for time-based reporting are met). In some cases the exam may be subsumed under the PM visit, so you can defer to the established E/M service to get to the higher level.

- *New patient as defined by the CPT manual.



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Coding Case Challenge: Newborn Visit

- The 3-5 Day Neonate Visit
 - Typically occurs within 3-5 days after discharge
 - Is it a preventive medicine service?
- OR
 - Is it a problem-oriented E/M service?
 - What ICD codes to report when baby is healthy?
 - How to report for a neonate who may have developed a problem but it no longer exists? (eg, jaundice)
 - What about a baby being checked for weight gain, but turns out to be normal?



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Coding Case Challenge

- Only report the service that was provided
- If an age appropriate preventive medicine service was performed, report that along with ICD-9-CM code V20.31 (age 8 days or younger) or V20.32 (8-28 days of age)
- If you are evaluating for suspected conditions, or if conditions have resolved since discharge, report a problem oriented E/M service along with ICD-9-CM codes V29.x (observation for suspected condition in the neonate period) or V67.9 (unspecified follow-up) and V20.31 or V20.32



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Counseling/Risk Factor Reduction

- Codes to promote health and prevent illness or injury
- Not to be used for counseling/risk factor reduction interventions to patients with established illness
- 99401 15 minutes
- 99402 30 minutes
- 99403 45 minutes
- 99404 60 minutes



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Counseling/Risk Factor Reduction

- Group Setting
 - 99411 30 minutes
 - 99412 60 minutes
- Other
 - 99420 Administration and interpretation of health risk assessment instruments



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Behavior Change Interventions, Individual

- 99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- 99407 intensive, greater than 10 minutes
- 99408 Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
- 99409 greater than 30 minutes



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Vaccines and Immune Globulins



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Vaccines/Toxoid Products

- 90476 – 90749
 - Identify the specific vaccine product only
 - Use in addition to administration codes
- Developed to meet reporting requirements
- Released twice per year (January and July) to accommodate new vaccines
- AAP Resource:
 - Vaccine Coding Table
 - <http://www.aap.org/en-us/professional-resources/practicesupport/financing-and-payment/Pages/Vaccines-Coding-Table.aspx>



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Pediatric Immunization Administration

- **90460** Immunization administration, through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
- **+90461** each additional component
 - (Use 90461 in conjunction with 90460)



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Other Qualified Health Care Professional

- CPT now defines this as
 "A 'physician or other qualified health care professional' is an individual who by education, training, licensure/regulation, and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports a professional service. These professionals are distinct from 'clinical staff.'"
- *Page xii of the *CPT 2014 Professional Edition* manual.



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Clinical Staff

- CPT now defines this as "a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service. Other policies may also affect who may report specified services."
- *Page xii of the *CPT 2014 Professional Edition* manual.



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Other Qualified Health Care Professional

- What does that mean?
 - Clinical staff (eg, RNs, LPNs) can no longer have codes 90460–90461 (immunization administration) reported to represent when they counsel patients or parents/guardians on vaccines.
 - If only clinical staff performs counseling, you must report a code from the 90471–90474 series as appropriate.



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Immunization Administration Vaccines/Toxoids

- 90471 Immunization administration; one vaccine (includes percutaneous, intradermal, subcutaneous, IM and jet injections)
- 90472 each additional vaccine
- 90473 Immunization administration, by oral or intranasal route; one vaccine
- 90474 each additional vaccine



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Immunization Administration

- If a significant separately identifiable E/M service is performed, the appropriate E/M service code should be reported in addition to the vaccine/toxoid administration codes.
- Modifier 25 should not be required when reporting immunization administration in addition to a preventive medicine service
- Modifier 25 will be required when reporting a problem-oriented E/M service (eg, 99213) in addition to immunization administration



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Immunization Administration

- If your physician or other qualified health care professional does not counsel on all vaccines given, then you cannot report the 90460/90461 for all of them. Only report the 90460/90461 for those counseled on. For those not counseled, defer to the 90473 and/or 90474
- Example: Your physician counsels a mom on the MMR, but not the annual influenza (intranasal)
 - Report 90460 and 90461 x2 (MMR)
 - Report 90474 (intranasal influenza)



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Vaccines and ICD Reporting

- When reporting vaccines and vaccine administration codes to payers what ICD-9-CM codes are required?
 - Under ICD-9-CM guidelines, only V20.2 is required when giving vaccines at the patient's well-baby or well-child exam
 - Codes V03-V05 were developed to link to the specific vaccines and administration when given outside of a routine well-baby or well-child exam
- However, some payers may still require specific V codes during routine well-baby or well-child exams, which goes against ICD guidelines



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NCCI Edits and Immunizations

- Currently a National Correct Coding Initiative Edit exists on all immunization administration codes and all E/M services (including PM)
- If you bill Medicaid or those private payers that have adopted NCCI edit logic, be sure to append modifier 25 to any E/M service when also reporting immunization administration.
- If performing a PM and E/M at the same encounter where vaccines are given, append modifier 25 to both the PM and E/M services.



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-25 modifier may be required on E&M service if vaccines administered on same DOS

- If vaccines administered as part of well-child or sick (99212-99215) visit- must add **-25 modifier to preventive care or E&M code** to get paid for both visit and immunization administration
 - NCCI edit (2013)
 - AAP appealing
 - Could get reversed in future
 - Need to add -25 modifier to E&M (not IA) code for now

The AAP Advocates for Deactivation of NCCI Edits

Updated May 23, 2013

On January 1, 2013 the Centers for Medicare and Medicaid Services (CMS) released the latest version of the National Correct Coding Initiative (NCCI) edits. The NCCI edits are code edits published by the Medicare and Medicaid to support correct coding and claims submission. Included in the new Medicare and Medicaid code edits are all of Current Procedural Terminology (CPT) evaluation and management (E/M) services that Medicare patients with immunization administration codes without the proper modifier. The modifier indicator for all these services is a "1" meaning that with proper modifier placement, the edit can be overruled.

The Academy is currently working with National Correct Coding Initiative - the CMS contractor for NCCI edits - to have the edits suspended on all preventive medicine services codes (99212-99215 and 99201-99205) and all immunization administration codes (90460 and 90471-90474).



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Immune Globulins

• 90281 – 90399

- Identify the immune globulin product only
- Use in addition to administration codes

• Example: RSV Immune Globulin

- 90378 (Product Code for Synagis)
- 50 mg each
- 96372 (Administration Code)
- Remember this is not a vaccine or toxoid, so do not report an IA code for administration.



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AAP: 99211 & Nurse only vaccine visits

- Code **99211** should not be reported for every nurse-only vaccine administration patient encounter.
- Rather, careful consideration needs to be given regarding the significance and medical necessity for such a visit.
- The following services are included in the immunization administration CPT codes:
 - **Administrative staff services**, such as making the appointment, preparing the patient chart, billing for the service, and filing the chart
 - **Clinical staff services**, such as greeting the patient, taking routine vital signs, obtaining a vaccine history on past reactions and contraindications, presenting a Vaccine Information Sheet (VIS) and answering routine vaccine questions, preparing and administering the vaccine with chart documentation, and observing for any immediate reaction



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AAP: What Additional Services Are Required to Appropriately Report a 99211?

- The E/M service must exceed those services included in the immunization administration codes.
- In addition, there are 2 principles to keep in mind. They are as follows:
 - The service must be medically necessary.
 - The service must be separate and significant from the immunization administration.
- When the provider (usually the nurse) evaluates, manages, and documents the significant and separate complaint(s) or problem(s), the additional reporting of **99211** is justified.
 - In such circumstances, the nurse typically conducts a brief history and record review along with a physical assessment (eg, indicated vital signs and observations) and provides patient education in helping the family or patient manage the problem encountered.
 - These nursing activities are all directly related to the significant, separate complaint, and unrelated to the actual vaccine administration.



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AAP: 99211 documentation

- Code **99211** is the one E/M service typically provided by the nurse and not the physician.
 - There are no required key components typical of the physician services noted above.
 - The typical time published in CPT for **99211** is 5 minutes.
- The American Academy of Pediatrics encourages documenting the date of service and reason for the visit, a brief history of any significant problems evaluated or managed, any examination elements (eg, vital signs or appearance of a rash), a brief assessment and/or plan along with any counseling or patient education done, and signatures of the nurse and supervising physician.
 - While not required, it may help payers to better understand the medical necessity of the nurse E/M service if it is linked to a different International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code than the one used for the vaccine given when appropriate.
 - Further, encounter documentation should be a separate entry from the charting of the vaccine itself (product, lot number, site and method, VIS date, etc, which usually are all recorded on the immunization history sheet).
- Finally, if the nurse provides the **99211** visit, it is reported under the physician's name/tax ID number, making it inherently an "incident to" service.
 - In such situations, it is a service restricted to established patients and requires the supervising physician's "direct supervision," as the physician being physically present in the office suite (not in the patient's room) and immediately available to provide assistance.
 - Most "nurse" E/M services are carried out under a protocol of orders developed by the physician for the particular service and should be fully documented in the record.
 - The physician supervising the care should sign the chart entry.
- Each practice should consider developing protocols and progress note templates for vaccine services.



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Other separately reportable preventive services



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Developmental/Behavioral Assessment

- Developmental "surveillance" is not separately reported
- Standardized **developmental screening** is reported with **96110**
- Standardized **autism screening** is reported with **96110**
- Standardized **depression screening** can be reported with **96110** unless otherwise directed by your payer (alternative **99420**)
- New code approved for behavioral/emotional screening – not due out until 2015.



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96110

- Was revised for 2012
- Can be reported "per" standardized tool administered on a given day
- Developmental surveillance or any screen that is NOT standardized is included in the PM service and not separately reported
- For multiple developmental screens given on the same day, report 96110 with multiple units with modifier 59 or on separate line items with modifier 59 appended to the subsequent code

• 96110



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Vision Screening

- **99173** - Screening test of visual acuity, quantitative, bilateral (eg. Snellen chart)
- **99174** - Instrument-based ocular screening including automated-refraction and photostereotyping
 - Both may be reported with preventive medicine services, but not reported together
 - Both may not be reported with a general E/M service of the eye



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New For CPT 2013: Instrument-based ocular screening- Payment and Payment Policy

- Fee 2013 Medicare – \$30.62 (NF)
- Payment Policy- AAP Updates Policy Nov 2012
 - may be electively performed in children 6 months to 3 years of ageas well as in older children who are unable or unwilling to cooperate with routine acuity screening.
 - recommended as an alternative to visual acuity screening with vision charts from 3 through 5 years of age, after which visual acuity screening with vision charts becomes more efficient and less costly in the medical home.
 - Alternatively, the use of vision charts and standard physical examination techniques to assess amblyopia in children 3 to 5 years of age in the medical home remains a viable practice at the present time.
 - Vision screening is a separately identifiable service and should not be bundled into the global code of well-child care.



<http://pediatrics.aappublications.org/content/130/5/983.full>

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Hearing Screen

- **92583** Hearing testing - Select picture
- **92552** Hearing testing – Puretone
- **92558*** OAE Screening
- **92587*** OAE limited evaluation
 - *Coverage may be limited by age and defined by individual payers.



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Laboratory Services

- **85018** Hemoglobin
- **86701** HIV-1Antibody
- **86689** HIV Confirmation (Western Blot)
- **83655** Lead
- **80061** Lipid Panel*
- **82465*** Total Cholesterol
- **83718*** HDL-C
- **87110** Chlamydia culture
- **87810** Chlamydia (rapid)
- **87850** Gonorrhea (rapid)
- **87590** Gonorrhea (direct probe technique)
- **36415/36416** Venipuncture/finger stick
 - *Do not report 82465 and/or 83718 if ordering a lipid panel (80061)



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PPD/TB Testing: 86580

- Remember:
- Applying the test-
 - bill only 86580- There is no additional code for the administration like vaccines, it is included in 86580
- Reading the test-
 - If the patient returns to have it read, this service is not included and can be reported separately
 - For a nurse-only visit, you can report 99211 and V74.1 (for a negative screen)
 - For a positive screen link the E/M service to 795.51 (positive PPD)



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Oral Health

- Perform a high risk assessment (can report 99420 if scored and results posted in chart)
- Refer to a dental home (if available)
- If patient is high risk and requires varnish application offer to family (if you can perform).
 - Many State Medicaid plans cover*
 - Most private payers do not
- *The AAP Section on Oral Health has a resource for State Medicaid plans and coverage (note codes are not listed – contact the coding hotline for specific codes)

• <http://www2.aap.org/oralhealth/docs/OHReimbursementChart.pdf>



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Alcohol and Drug Use Assessment

- CRAFFT Is recommended for positive assessment
- When the CRAFFT is done alone – code **99420**
- When the CRAFFT is done and if positive and a brief intervention service is also performed – code **99408** instead.
 - 99408 – requires a minimum of 7.5 minutes of time (threshold) spent on the screening and intervention service.
 - If minimum time is not met and documented, report only the 99420.
 - Do not report the 99420 in addition to the 99408 for the same screening tool.



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CRAFFT Screen

- CRAFFT screening tool information:

• <http://www.ceasar-boston.org/CRAFFT/>



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Tobacco Cessation Counseling

- **99406** Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 mins up to 10 mins
- **99407** intensive, greater than 10 mins

- Caveat: Can only be reported under the patient being counseled. Cannot be reported when counseling a parent or guardian under your patient.



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Code for Other Procedures!

- Remember: Report procedures that may be done in addition to the PM service such as:
- **17250** Umbilical Granuloma Cautery
- **54150** Circumcision/newborn
- **69200** Foreign body removal/ear
- **30300** Foreign body removal/nose
- **10120** FB removal w/ incision/subcutaneous
- **10060** Incision & Drainage/Simple
- **17110** Wart removal (1-14)
- *Always append modifier 25 to the PM service when reporting these services in addition.



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Coding that Supports the Medical Home



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Coding That Supports the Medical Home

1. Code correctly all services – especially those with high volume
2. New services added to improve the comprehensive care model
3. Services for expanded access
4. Services for care management and coordination



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You report...

You evaluate a teen for frequent asthma exacerbations – the visit takes 21 minutes, most of which is spent counseling on med compliance- you report

1. 99212
2. 99213
3. 99214
4. 99215



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99214 is correct

- The typical times in CPT-
 - 99212 - 10 min
 - 99213 - 15 min
 - 99214 - 25 min
 - 99215 - 40 min



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Time Based Coding

- When counseling and/or coordination of care dominates (>50% of visit time) the physician-patient or family encounter time shall be considered the key or controlling factor in the selection of a particular level of E/M services
 - for E/M services assigned a "typical time"



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E/M Services- Time Based Coding

- Intraservice times are defined as
 - face-to-face time in the office or other outpatient setting
 - floor/unit time in the hospital or nursing facility
- Includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members
 - e.g. foster parents, person acting in loco parentis, legal guardian



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Time Based Coding

- A unit of time is attained when the mid-point is passed
 - for example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed
- When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used



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E/M Typical Times

	Typical Time	Minimum Time
99201	10 min	N/A
99202	20 min	16 min
99203	30 min	26 min
99204	45 min	38 min
99205	60 min	53 min
99211	5 min	N/A
99212	10 min	8 min
99213	15 min	13 min
99214	25 min	21 min
99215	40 min	33 min



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Documentation Requirements

• Documentation MUST state

- Total face-to-face time with patient/family
- What was discussed (in detail)
- Total time spent in counseling or coordination of care
 - I spent 40 minutes with the patient and her mom, discussing (XX). Of that 40 minutes I spent 30 minutes counseling.
 - I spent 40 minutes with the patient and her mom, of which greater than 50% was spent in counseling. We discussed (XX).



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What a difference time makes (Medicare Fee Schedule)

CPT code	Non-facility RVU/MC\$	Difference (from previous level)
99212	1.22/\$41.45	
99213	2.03/\$68.97	+0.81/\$27.52
99214	3.01/\$102.27	+0.98/\$33.30
99215	4.05/\$137.60	+1.04/\$35.33



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E/M Documentation Guidelines Levels of History

Level of History	CC	HPI		ROS		PFSH	
		CPT	CMS	CPT	CMS	CPT	CMS
Problem Focused	Required	Brief	1-3 elements	Not Required		Not Required	
Expanded Problem Focused	Required	Brief	1-3 elements	Problem Pertinent	1 system	Not Required	
Detailed	Required	Extended	≥4 elements OR ≥3 chronic or inactive conditions	Extended	2-9 systems	Pertinent	1 item
Comprehensive	Required	Extended	≥4 elements OR ≥3 chronic or inactive conditions	Complete	≥10 systems	Complete	2 or 3 items

CC – Chief Complaint
HPI – History of the Present IllnessROS – Review of Systems
PFSH – Past, Family, Social History

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E/M Documentation Guidelines Levels of Physical Examination

Level of Physical Exam	CPT Definitions	CMS (Medicare) Documentation Guidelines	
		1995 Guidelines	1997 Guidelines
Problem Focused	Limited exam of affected body area	1 body area or organ system	1-5 bullets in one or more areas/systems
Expanded Problem Focused	Limited exam of affected body area + other symptomatic or related organ systems	2-4 body areas/organ systems including affected area	6-11 bullets in one or more areas/systems
Detailed	Extended exam of affected body area + other symptomatic or related organ systems	5-7 body areas/organ systems including affected area	12 or more bullets in 2 or more areas/systems OR at least 2 bullets from 6 or more areas/systems
Comprehensive	General multi-system exam or complete examination of single organ system	8 or more organ systems	at least 2 bullets from 9 or more areas/systems

It is the physician's choice which rule to use
examined within a system or area

"Bullets" are specific items

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EM Documentation Guidelines Medical decision making

Two of the three elements in the table must be either met or exceeded to determine the level of decision making

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low complexity
Multiple	Moderate	Moderate	Moderate complexity
Extensive	Extensive	High	High complexity



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Key Point: E/M Documentation Guidelines

- CMS Provides Guidance on Selecting Levels of E/M Codes
 - Hx and PE documented **should be medically necessary** to manage the problem for the encounter
 - Documented extraneous information should not be used to upcode E/M Levels
 - Major risk of EMR templates- "Upcoding"



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Dr. Joel Bradley's "Art & Science of Coding"

- CMS E/M Documentation Guidelines
- Two Versions-from CMS
 - 1995 and 1997- can use either
- Used by all Federal and most private payers
- <http://www.cms.gov/MLNEdWebGuide/>



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The "Art" of Coding

(Joel Bradley, MD, Past Editor AAP *Coding for Pediatrics*)

- **E&M = EVALUATION & MANAGEMENT** (Office visit)
 - 99211 – nurse visit
 - 99212 – easy, brief problems
 - (diaper rash, thrush)
 - 99213 – average, usual problems
 - (fever & pharyngitis, acute otitis media)
 - 99214 – "oh no"
 - (chronic or multiple problems, school-behavioral issues, complicated acute issues)
 - 99215 – "just ran a marathon" post-visit feeling
 - (new ADHD evaluation, headache & vomiting)
- YOU should select the proper code, not office staff
- The "art" defines coding starting point- the final code is defined by coding rules (the "science" of coding)



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99211

- TYPICAL PRESENTING PROBLEMS
 - Interpret TB Skin test
 - Newborn weight check by the nurse
 - Obtaining a throat culture
 - Monitoring elevated blood pressures and medicine compliance



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99212

- TYPICAL PRESENTING PROBLEMS
 - Diaper rash
 - Otitis Media recheck-resolved
 - Otitis Externa
 - Thrush



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99213

- TYPICAL PRESENTING PROBLEMS
 - Fever and pharyngitis
 - UTI- cystitis
 - URI and Otitis
 - Mild Lower Respiratory Infections
 - Moderate injury
- Most Acute Uncomplicated Illness/Problems



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99214

• TYPICAL PRESENTING PROBLEMS

- Chronic or Multiple Problems
 - Headaches, Abdominal Pain
 - Fatigue, Anorexia
 - Asthma, Diabetes
- School, Behavioral Problems
 - ADD –return visits
- Acute Complicated Illnesses
 - Fever without focus
 - Influenza



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99215

• TYPICAL PRESENTING PROBLEMS

- Diabetes complicated by influenza
- Headaches with vomiting
- Abdominal pain, disabling
- Fatigue, anorexia in teen
- Fever without focus <60 days
- School, behavioral problems
- ADD –initial evaluation



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Key Factory: The History

- Consists of:
 - Chief Complaint (CC)
 - History of Present Illness (HPI)
 - Review of (Pertinent) Systems (ROS)
 - Past, Family, Social History (PFSH)
- Everything listed above can be documented by ancillary staff except for the HPI
- Important to remember that only pertinent history obtained should be counted towards your history level (eg, history related to the CC)



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Levels of History

Level of History	Chief Complaint (CC)	History of Present Illness (HPI)		Review of Systems (ROS)		Past, Family, Social History (PFSH)	
		CPT	Medicare	CPT	Medicare	CPT	Medicare
Problem Focused	Required	Brief	1-3 elements	Not Required		Not Required	
Expanded Problem Focused	Required	Brief	1-3 elements	Problem-Pertinent	1 system	Not Required	
Detailed	Required	Extended	4 + elements OR 3+ chronic or inactive conditions	Extended	2-9 systems	Pertinent	1 element
Comprehensive	Required	Extended	4 + elements OR 3+ chronic or inactive conditions	Complete	10 systems	Complete	2 or 3 elements



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Key Factor- History

- Examples:
 - Expanded:
 - HPI: 7 y/o patient presents with a productive cough. Started 3 days ago and is worse at night. (3 elements)
 - ROS: Constitutional: No Fever (1 element)
 - PFSH: No allergies (1 element)
 - Detailed:
 - HPI: 3 y/o patient presents with a productive cough. Started 3 days ago and is worse at night. Fever on and off for 3 days, highest was 103.4 yesterday. Comes down with Motrin, but only to 100. Cough not improved with OTC rx. (4 elements)
 - ROS: Integumentary: ENT: rhinorrhea; GI: still eating, no emesis; GU- voids normally (3 elements)
 - PFSH: Noted that mom and grandma smoke around patient occasionally. Patient was also diagnosed with pneumonia at age 2. (2 elements)



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Key Factor- Physical Examination

- 2 Sets of Guidelines:
 - 1995 (Less complex, no bullet points)- best for general pediatrics
 - 1997 (Very specific, uses bullet points- necessary for many subspecialties)
- Not limited to one set or the other
- Like the history, only count the pertinent body areas or systems that relate to the CC



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Body Areas/Organ Systems in the Physical Exam

CPT	Medicare	
	1995 Guidelines	1997 Guidelines
Body Areas: abdomen; back, including spine; chest, including breast & axillae; genitalia/groin/buttocks; head, including face, each extremity, and neck. Organ Systems: cardiovascular; ears/nose/mouth/throat/ eyes; GI; GU; hematologic/lymphatic/immunologic; musculoskeletal; neurologic; psychiatric; respiratory; and skin	Body Areas: abdomen; back, including spine; chest, including breast & axillae; genitalia/groin/buttocks; head, including face; each extremity, and neck. Organ Systems: cardiovascular; constitutional; ears/nose/mouth/throat/ eyes; GI; GU; hematologic/lymphatic/immunologic; musculoskeletal; neurologic/psychiatric; respiratory; and skin	Body Areas/Organ Systems: General multi-system exam: cardiovascular; chest/breasts; constitutional; ears/nose/ mouth/throat; eyes; GI; GU; hematologic/lymphatic/immunologic; respiratory; musculoskeletal; neck; neurologic; psychiatric; and skin Genitourinary single system exam: constitutional; cardiovascular; GI; GU; lymphatic; neck; neurological/ psychiatric; respiratory; and skin



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Levels of Physical Examination

"Bullets" are 1997 specific items examined within a system or area.

Level of Physical Exam	CPT Definitions	Medicare Documentation Guidelines	
		1995 Guidelines	1997 Guidelines
Problem-Focused	Limited exam of affected body area	1 body area or organ system	1-5 bullets in one or more organ systems/body areas
Expanded Problem- Focused	Limited exam of affected body area + other symptomatic or related organ systems	2-4 body areas/organ systems including affected area	6-11 bullets in one or more organ systems/body areas
Detailed	Extended exam of affected body area + other symptomatic or related organ systems	5-7 body areas/organ systems including affected area	12 or more bullets in two or more organ systems/body areas
Comprehensive	General multi-system exam or complete examination of single organ system	8 or more organ systems	General multi-system exam: 2 bullets from 9 different body areas/organ systems Genitourinary single system exam: specific number of bullets from 3 body areas/organ systems + any 1 element from 6 other body areas/organ systems



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Physical Examination

- Examples*:
 - Expanded: T 101, p-82, BP 66/94: alert and smiles; throat – mild erythema, TM's both mobile with normal landmarks, nares are red with edema; lungs are clear – no retractions. (3 elements)
 - Detailed: T- 99.8, p 69, R- 28 ; pale skin; nose – purulent discharge, TM's red and bulging; Lungs- mild subcostal retractions and rales both sides ; heart without murmur; abdomen is soft without mass or tenderness (5 elements)



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Medical Decision Making

- There are 3 components of MDM:
 - # of Diagnoses or Management Options
 - Amount/Complexity of Data
 - Risk of Complications (Morbidity/Mortality)
- Must meet 2 of the 3 to reach the MDM level of service
- **KEY POINT: MDM will always be the driver behind your E/M service level**



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Key Element- Medical Decision Making

Elements Included in Medical Decision Making Component- Select level with two of three

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of Medical Decision Making
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	<u>Moderate</u>	<u>Moderate</u>	<u>Moderate Complexity</u>
Extensive	Extensive	High	High Complexity



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Medical Decision-Making Risk Table

select level of highest one element

Level of Risk	Presenting Problems	Diagnostic Procedures	Management Options
Minimal	1 self-limited	Lab test: Venipuncture	Bandages/rest/drug
Low	2 or more self-limited 1 stable chronic illness Acute uncomplicated illness or injury	Superficial needle bx Lab test: Arterial puncture Single x-ray Physiologic tests	OTC drugs Minor surgery OT
Moderate	1 or more chronic illness with mild exacerbation 2 or more stable acute illnesses with systemic symptoms Acute complicated injury Undiagnosed new problem; with uncertain prognosis	Multiple x-rays Deep-needle bx LP; joint aspiration CT, MRI Cardioimaging	Minor surgery with risks Elective major surgery <u>Prescription drugs</u> Closed tx of fx
High	1 or more chronic illness with severe exacerbation Acute illness with threat to life/limb Abrupt change in neurologic status	Discography Myelography Arthrogram	Elective major surgery with risks/ER major surgery Parenteral controlled substance/drug therapy with intensive monitoring DNR



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'POINT' method to determine type of medical decision making (not CMS)

Number of diagnoses or management options	Points	Amount and/or complexity of data to be reviewed	Points
Self-limited or minor (max = 2)	1	Review and/or order clinical/lab tests, radiology tests or tests in CPT medicine section (max = 3)	1 each class of test
Established problem to examiner, stable/improved	1	Discussion of test results with performing physician	1
Established problem to examiner, worsening	2	Decision to obtain old record and/or obtain history from someone other than patient	1
New problem to examiner, no additional workup planned (max = 1)	3	Review, summarize old records and/or obtain history from someone other than the patient and/or discussion of case with another health care provider	2
New problem to examiner, additional workup planned	4	Independent visualization of image, tracing or specimen (not report review)	2
Number of diagnoses or management options points	s1 (minimal)	2 (limited)	3 (multiple)
Amount and/or complexity of data to be reviewed points	s1 (minimal/phone)	2 (limited)	3 (multiple)
Risk of complications and/or morbidity or mortality	Minimal	Low	Moderate
Type of decision making- MDM= highest 2 of 3	Straightforward	Low complexity	Moderate complexity



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Office/Outpatient Services—Established Patient

Document 2 or 3 key components (history, examination, & MDM) OR time spent counseling the patient.

	99211	99212	99213	99214	99215
	History				
Level of History	Not Required	Problem-Focused	Expanded Problem-Focused	Detailed	Comprehensive
CC	Not Required	Required	Required	Required	Required
HPI	Not Required	1-3 elements	1-3 elements	4+ elements OR 3+ chronic or inactive conditions	4+ elements OR 3+ chronic or inactive conditions
ROS	Not Required	Not Required	1 system	2-9 systems	10-14 systems
PFSH	Not Required	Not Required	Not Required	1 of 3 elements	2 of 3 elements
	Physical Examination				
Level of Examination	Not Required	Problem-Focused	Expanded Problem-Focused	Detailed	Comprehensive
1995	Not Required	1 system	2-4 systems	5-7 systems	8 or > systems
1997	Not Required	1-5 elements	6-11 systems	12 elements in 2 systems	18 elements—2 in each of 5 systems
	Medical Decision Making				
Level of MDM	Not Required	Straightforward	Low	Moderate	High
	Face-to-Face Time				
Typical Times	5 min supervision*	10 min	15 min	25 min	40 min
	Relative Value Units/2012 Medicare Payment Conversion Factor = \$34.04				
RVU's	0.58/\$19.74	1.25/\$42.55	2.07/\$70.46	3.06/\$104.16	4.11/\$139.89



*Physician must be in the office during the E/M service.

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Office/ Outpatient Services—New Patient

Document all 3 key components (history, examination, & MDM) OR time spent counseling the patient.

	99201	99202	99203	99204	99205
	History				
Level of History	Problem-Focused	Expanded Problem-Focused	Detailed	Comprehensive	Comprehensive
CC	Required	Required	Required	Required	Required
HPI	1-3 elements	1-3 elements	4+ elements OR 3+ chronic or inactive conditions	4+ elements OR 3+ chronic or inactive conditions	4+ elements OR 3+ chronic or inactive conditions
ROS	Not Required	1 system	2-9 systems	10-14 systems	10-14 systems
PFSH	Not Required	Not Required	1 of 3 elements	3 of 3 elements	3 of 3 elements
	Physical Examination				
Level of Examination	Problem-Focused	Expanded Problem-Focused	Detailed	Comprehensive	Comprehensive
1995	1 system	2-4 systems	5-7 systems	8 or > systems	8 or > systems
1997	1-5 elements	6-11 elements	12 elements in 2 systems	18 elements—2 in each of 5 systems	18 elements—2 in each of 5 systems
	Medical Decision-Making				
Level of MDM	Straightforward	Straightforward	Low	Moderate	High
	Face-to-Face Time				
Typical Times	10 min	20 min	30 min	45 min	60 min
	Relative Value Units (RVU)/2012 Medicare Payment Conversion Factor = \$34.04				
RVU's	1.25/\$42.55	2.13/\$72.50	3.09/\$105.18	4.72/\$160.66	5.86/\$199.46



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E/M Level Examples: Asthma

99211 Nurse reviews inhaler technique (94664) and obtains a peak expiratory flow rate for a well 10-year-old established patient. She reviews a disease management protocol with mother and child and teaches child home monitoring.	Hx—None Required	PE—None Required	MDM—None Required
99212 Follow-up visit for an 8-year-old with stable asthma who is in good health	Hx—Problem Focused 1. Chief complaint—asthma 2. Brief history of present illness a. Cough b. Wheeze c. Labored breathing	PE—Problem Focused Limited to respiratory system; a peak expiratory flow rate may be obtained.	MDM—Straightforward 1. Continue current medications 2. Routine follow-up



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E/M Level Examples: Asthma

99213 Follow-up visit for a child with stable chronic asthma who is using a metered-dose steroid inhaler with beta-agonist as needed	Hx—EPF 1. Chief complaint—asthma 2. Brief HPI a. Cough, including nocturnal symptoms b. Wheeze c. Respiratory distress d. Exercise tolerance e. Frequency of rescue medication use f. Peak flow monitoring at home g. Associated illnesses and problem-pertinent ROS	PE—EPF 1. Examination of respiratory system including lungs, nose, throat, and other pertinent organ systems 2. A peak expiratory flow rate may be obtained.	MDM—Low Complexity 1. Review of home peak flow data 2. Evaluation of medications 3. Alteration of medications 4. Criteria for urgent follow-up care 5. Plans for routine follow-up care
99214 An 8-year-old with known unstable asthma is examined because of an acute exacerbation of the disease; already receiving inhaled albuterol and inhaled steroids by metered-dose inhaler.	Hx—Detailed 1. Chief complaint—asthma 2. Extended HPI—as above 3. Pertinent PFSH—NKA, in school—several kids are sick with the flu.	PE—Detailed 1. General appearance 2. Ears, nose, throat 3. Neck, lymph 4. Respiratory 5. Cardiovascular 6. Abdomen	MDM—Moderate As in 99213 plus 1. Treatment with a nebulized beta-agonist in office and at home 2. Use of oral steroids 3. Discussion of effects of medications 4. Limitations on physical activity



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E/M Level Examples: Asthma

99215 A 1-year-old child known to have recurrent wheezing following respiratory syncytial virus bronchiolitis has had increasingly frequent attacks during the past 2 months. New infiltrates are revealed by chest radiograph. Laboratory evaluation since last visit documented a positive sweat test. A diagnosis of cystic fibrosis is made.	Hx—Comprehensive 1. Chief complaint 2. Extended HPI—as previous 3. Complete ROS—as previous + all other systems asked and are negative 4. Complete PFSH	PE—Comprehensive As in 99214, plus 1. Eyes (steroid use—look for cataracts) 2. Skin	MDM—High Complexity 1. Review laboratory data and radiology results. Review prior PFTs done off-site, letter from school nurse. 2. Consult with pulmonologist by telephone. 3. Initiate therapy with multiple prescription medications including oral steroids—review of adverse effects and their duration. 4. Develop new asthma action plan. 5. Discuss implications of positive sweat test with parent(s).
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You report...

You see a 9 month old for a well baby visit- she has bronchiolitis- you perform the PM - and the EM service to treat the condition taking 15 minutes extra- you report the following CPT codes:

1. 99391 alone
2. 99391 + 99213
3. 99391 + 99213-25
4. 99391 + 99212



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99391 + 99213-25

Modifier-25

- This modifier is used when a **significant, separately identifiable E/M service** is provided by the same physician **on the same day** as another procedure or other service
- There needs to be **additional documentation** to substantiate the additional service
- **The modifier is always associated with the E/M code**
 - do not place with a non-E/M code



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Modifier -25

- Use the -25 modifier with the "sick visit" E/M code when reported with a preventive medicine visit
- use new patient outpatient/office visit code (99201-99205) when a separate problem is evaluated and reported with a new preventive medicine service



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Well and Sick visit

- What is Significant?
 - a separate visit would have been required to take care of the problem
 - a problem requires an Rx to treat
- What is Separate?
 - additional documentation is needed
 - separate documentation helps you select the correct E/M code level
 - additional history, exam and MDM
 - separate documentation also helps you with an audit-keeps auditors happier
 - just like legible writing



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You bill which codes?

A 9 month has a nurse visit solely to catch up on vaccines - your nurse does the vaccine counseling - you bill which codes

1. 90460/90461
2. 99211
3. 90471-74
4. 99211 + 90471-4



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90471-4

- Nurse (office staff) did counseling, not you
- Use the existing family 90471-4
- If MD, PA, or NP did counseling use 90460/90461
- VFC regulations- vary by state- most use 90460 for each vaccine given
- VFC coding/billing regulations changing- new Federal guidelines soon



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Immunization Administration For Patient Through 18 years of age

90460 via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component use for each vaccine administered

90461 each additional vaccine/toxoid component list separately in addition to code for primary procedure (90460)

For vaccines with multiple components (combination vaccines), report 90460 in conjunction with 90461 for each additional component in a given vaccine

These new codes replaced 90465-8



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New 2011 vs. Old pediatric immunization administration codes- DTaP, MMRV,

2010		2011	
CPT	RVU	CPT	RVU
90465	0.67	90460	0.68 x 2
90466	0.36 x 1	90461	0.34 x 5
Total	1.03	Total	3.06



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What's the difference: physician vs. nurse counseling DTaP, MMR-V

Physician Counseling		Nurse Counseling	
CPT	RVU	CPT	RVU
90460	0.68 x 2	90471	0.68
90461	0.34 x 5	90472	0.34 x 1
Total	3.06	Total	1.02



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Let's practice a few cases



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Coding Case 1

- A 1-month old (est pt) presents for her preventive medicine service. An age appropriate history is taken and an exam is performed. During the exam, the physician noted a granuloma on the patient. The physician inquires from the mom about it. She says its been there about 2 days, but had not bothered her.
- The physician decides to cauterize it. Speaks with the mom about the procedure and the mom consents. Follow-up care instructions are given. What should be reported?
- 99391 25 and 17250



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Case 2

- A 15-year-old (new pt) presents for his annual well check. An age appropriate history is taken and an exam done. During the history it is noted that he is a tobacco smoker. The physician performs age appropriate counseling, but also spends about 8 mins documented time talking about his tobacco use and cessation methods.
- The physician provides him with materials to assist in his cessation, and offers to write him a prescription if the methods are unsuccessful.
- What should be reported?
- 99384 25 and 99407



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Case 3

- A 6-year old (est pt) presents for his well-child check. This patient has Type 1 Diabetes that is well controlled on insulin. During the history and exam, the physician asks the mom how the child is doing and she states that he has been stable and his blood sugars are staying where the endocrinologist wants them. The physician notes all of this in the chart. The mom then asks for a referral back to the endocrinology as they are schedule to see him next month.
- The physician notes in the chart that a referral is to be written. What should be reported?



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Case 4

- A 6-month old presents for his well check. He is due for his DTaP, Prevnar and Hepatitis B. The physician completes an age appropriate preventive medicine service and counsels the mom on the vaccines. What should be reported?
- 99391* 90700
- 90460 (with 3 units) 90670
- 90461 (with 2 units) 90744
- *If the payer follows NCCI edits, you will have to append modifier 25



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Case 5

- A 12-year-old presents for his well-child check. His dad tells the nurse that last night he woke up with some difficulty breathing so he had to use his prescribed inhaler. He felt better this morning, but continued to use the inhaler as prescribed today. The nurse takes a ROS and updates the PFSH related to his asthma. The doctor comes in and addressed the asthma issue first. He determines that a nebulizer treatment is needed. The nebulizer is given, he is rechecked.
- The patient is better and the physician does continue with the preventive medicine service. He writes up prescriptions for another inhaler as well as new medication for the nebulizer the patient has at home. What is to be coded?



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Coding for new services you might add to your Medical Home practice-

- Obesity/Nutrition- Using some special codes
- Behavioral Services - Key will be:
 - learning and using psych codes
 - getting credentialed with payers



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Behavior change intervention

Often credentialed for both medical and behavioral health providers

Health hazard appraisal
99420 administration & interpretation of health risk assessment instrument
• RVU 0.30/\$10.19

Smoking and tobacco use cessation counseling
99406 3-10 minutes
• RVU 0.40/\$13.59

99407 >10 minutes
• RVU 0.78/\$26.50

Alcohol and/or substance abuse intervention requires use of standardized tool (e.g. DAST)

99408 15-30 minutes
• RVU 1.02/\$34.66

99409 >30 minutes
• RVU 1.98/\$67.27



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Reporting obesity care

Physician can report office visit based on time when counseling and coordination of care dominate (> 50%)

99201-5, 99212-5

add 99354-5 for prolonged office face-to-face service ≥30 minutes or more beyond typical time for the encounter (only on highest level code within series if entire visit was spent on counseling)

Risk factor reduction counseling (at risk for obesity)

99401-4 individual
99411-2 group

Physician education services to patients in a group setting with an established condition

99078 may be reported on same day as E/M
• no published RVU



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Reporting obesity care

QHCP may report counseling risk factor reduction & behavior change intervention services

Registered dietitians (RD) and/or state licensed nutritionists may report –

medical nutrition therapy-

97802	initial assessment and intervention, each 15 minutes face-to-face with an individual
97803	reassessment and intervention, each 15 minutes
97804	group of 2 or more, each 30 minutes



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HCPCS codes for obesity care

S9470	Nutritional counseling, dietitian visit
S9452	Nutrition classes, non-physician provider, per session
S9449	Weight management classes, non-physician provider, per session

- no published RVU's= carrier priced
- check with payers for coverage



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Coding That Supports the Medical Home: Special Services

99050 – 99058 Special Services Add-on Codes



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Do you report additional codes...

You keep your office open in the evening to see add-on sick patients during influenza season- do you report any additional codes for this service?

- No- EM code only
- Yes- 99051 + EM code
- No- 99050 only
- 99050 + EM code



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99050 + EM Code

- Allows extra revenue for the expense associated with keeping office open
- For service after your published office hours
- First establish your hours-
 - Regular weekday office hours , or
 - Regular office hours- nights, weekends , holidays
- 99050 is used for services scheduled outside of these hour



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Special services- payers increasingly cover these

99050	Service provided other than regularly scheduled office hours or on days when office is normally closed
99051	Service provided during regularly scheduled evening, weekend and holiday hours, in addition to basic services
99058	Service provided on emergency basis which disrupts other scheduled office services, in addition to basic service



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Special services- usually not covered by payers

- | | |
|-------|---|
| 99060 | Service provided out of the office on an emergency basis which disrupts other scheduled office services, in addition to basic service |
| 99070 | Additional supplies and materials over and above those usually included with office visit |
| 99080 | Special reports <ul style="list-style-type: none"> • more than usually provided in standard report • e.g., insurance forms, fitness reports |



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Telephone calls- is anyone listening?

MD Code	Time (Mins)	RVU NF	\$MC	QHCP Code
99441	5-10	0.40	13.61	98966
99442	11-20	0.77	26.20	98967
99443	21-30	1.14	38.79	98968

- Established patient or patient parent/guardian
- Not originating from E/M service within past 7 days
- Not leading to E/M service within the next 24 hours or soonest available appointment
- **Medicare payment= \$0**
- 99444 Online E/M service provided to established patient



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Care Coordination services



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Services for care management and coordination (2013)

- | | |
|----------|--|
| 99339-40 | Care Plan Oversight- existing code |
| 99487-89 | Complex chronic care coordination services (new code 2013) |
| 99495-6 | Transitional care management services (new code 2013) |



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ADHD: chronic condition management

- You are managing a 12 year old boy with ADHD with both medication and behavior interventions at school
- You speak with the a school counselor and parents on an ongoing basis making adjustments in his medication and school activities
- Can you report this service?
 - Yes, prolonged service without direct contact
 - Yes, care plan oversight
 - Yes, complex chronic care coordination
 - No, it is part of his office E/M service



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Care plan oversight

- Oversight of services for children with special healthcare needs and chronic medical conditions by primary care physicians
- Coordinate medical care management with other medical and non-medical service providers and family
- May encompass oversight of work or school programs the patient may be attending where therapy is provided
- Includes:
 - Review of patient records, reports, labs
 - Communications for assessment and care decisions
 - Other health care professional
 - Family, caregiver or guardian



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Care plan oversight

Service	15-30 minutes	> 30 minutes
Home services not involving home health agency	99339 2.25 RVU	99340 3.15 RVU
Home health agency	99374 2.03 RVU NF	99375 3.04 RVU NF
Hospice	99377 2.03 RVU NF	99378 3.04 RVU NF

- Patient is not present
- Services are “per calendar month”



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AAP Worksheet: Care Plan Oversight Encounter



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Example: Care Coordination documentation

Patient Name: Peppermint Patti MR # 12345			Physician: Charlie Brown, MD	
Date	Start Time	Activity	End Time	Total
05/29/2012	7:40 am	Mother phoned Patti is having more difficulty swallowing. Will arrange testing as discussed at last visit.	7:45 am	5 min
05/29/2012	7:45 am	Scheduled FEES at Children's Hospital 06/02/2012 at 8:00 am; phoned Ms Patti with information on test.	7:50 am	5 min
06/03/2012	7:05 pm	Discussed results of FEES with Ms Patti; will obtain evaluation by speech language pathologist for therapy recommendations.	7:20 am	15 min
06/12/2012	6:15 pm	Reviewed evaluation and approved therapy plan from speech pathology.	6:25 pm	10 min

Total Time-Months: 35 minutes

CPT code 99340

Abbreviation: FEES, Fiberoptic endoscopic evaluation of swallowing.



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Frequent ED visits

- Timmy was seen in the emergency department last weekend for exacerbation of asthma
- He has been to the ED 6 times in the last year and had an admission to the ICU for several days last year
- You, his established PCP, want to help Timmy avoid exacerbations by educating his caregivers about preventive medications and appropriate response to asthma symptoms



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Frequent ED visits

- You can help Timmy by providing
 - Individual preventive medicine counseling
 - Care Plan oversight
 - Chronic complex care coordination
 - Transitional care management



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Complex Chronic Care Coordination (C4)

- Beyond typical pre- and post-E/M service
- Patient-centered- addressing medical, functional, social
- Recognizes team-based approach to care
- Aligns with concept of medical home coordinating and facilitating care



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“Complex Chronic Conditions”

- Continuous or episodic expected to last at least 12 months
- Significant risk of death, acute exacerbation, acute decompensation, or functional decline
- Commonly require coordination of specialty services
- May have co-morbidities, social support weaknesses, access to care issues



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Complex chronic care coordination codes

C4 Code	Description	RVU
99487	1 st hour of clinical staff time (directed by MD or QHCP) with no face-to-face visit; per calendar month	2.41 RVU
99488	1 st hour of clinical staff time (directed by MD or QHCP) with one face-to-face visit; per calendar month	5.40 RVU
+99489	Add-on for each additional 30 minutes-reported in conjunction with 99487 or 99488	1.21 RVU

- Covers clinical staff directed by a physician or other QHCP
- Per calendar month



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Beyond typical pre- and post-E/M service

- Communicating with patient/caregiver regarding aspects of care
- Communication with home health, community services
- Collecting health outcomes data, patient registry
- Educating patient/caregivers on self-management, independent living, activities daily living
- Assessing and supporting treatment regimen adherence and medication management
- Identifying community and health resources
- Facilitating access to care and services
- Developing and maintaining comprehensive care plan



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Hospitalization: discharge planning & follow-up care

- Mariah is a 5 yo who is discharged after overnight observation following a breakthrough seizure
- She has a VP shunt for acquired hydrocephalus secondary to neonatal meningitis
- In addition to her seizure disorder, she has partial blindness, hearing loss, and delayed milestones



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- You can help Mariah by providing:
 - A. Individual preventive medicine counseling
 - B. Care plan oversight
 - C. Complex chronic care coordination
 - D. Transitional care management



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Transitional Care Management (TCM) services (99495 – 99496)

- Manage transition of patient whose medical and/or psychosocial problems require moderate- to high-complexity decision making
 - From: inpatient, observation care or SNF
 - To: patient's home, domiciliary, assisted living facility
- New or established patient (2014)



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Transitional Care Management elements

TC Code	Communication	MDM Complexity	Face-to-Face Visit within	RVU (NF)
99495	2 business days	Moderate	14 days D/C	4.82
99496	2 business days	Severe	7 days D/C	6.79

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- MDM = Medical decision making complexity during service period
- Face-to-face visit within x calendar days of discharge



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TCM Requirements

- Covers services beginning the day of discharge and continues through next 29 days
- **Interactive contact** with the patient or caregiver must occur within 2 business days of discharge
 - F2F, phone or electronic
- Must be a **face-to-face visit** within 7 (moderate MDM) or 14 (high MDM) calendar days
 - Medication reconciliation and management must occur no later than day of 1st F2F visit
 - Additional visits after 1st F2F visit may be separately reported
 - Another TCM service may not be reported by the same provider/group for any subsequent discharges within 30 days



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TCM Providers

- Physician or QHCP
- Licensed clinical staff provide services under physician supervision
 - RN, LPN
 - Licensed social worker, psychologist
 - Licensed nutritionist
 - Licensed therapist



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Physician or QHCP Non-Face-to-Face Services

- Obtain and review discharge information (eg discharge summary, as available, or continuity of care documents)
- Review need for follow-up on pending diagnostic tests and treatments
- Interact with others who will assume or resume care of the patient's system specific problems
- Educate patient, family, guardian, and/or caregiver
- Establish or reestablish referrals and arrange for needed community resources
- Assist in scheduling any required follow-up with community providers and services



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Licensed Clinical Staff Non-Face-to-Face Services

- Communicate aspects of care with patient, family members, guardian, caretaker, surrogate decision makers, and/or professionals
- Communicate with home health agencies and community services utilized by the patient
- Educate patient, family, caretaker supporting self-management, independent living & activities of daily living
- Assess and support treatment regimen adherence and medication management
- Identify available community and health resources
- Facilitate access to care and services needed by the patient and/or family



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TCM: Initiation

- Mariah's PCP receives notification of her discharge from the nurse on the observation unit
- Mariah's PCP receives and reviews observation/discharge records
- Practice LPN phones Mariah's mother the next morning:
 - explaining TCM services
 - verifies understanding of discharge instructions, current medications
 - schedules appointment within 7 calendar days at time most convenient to Mariah's needs



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TCM: Physician visit

- Mariah's pediatrician and RN develop visit agenda
- The pediatrician reviews test/study results not available on day of discharge
- The face-to-face visit is within 7 calendar days of discharge
- The pediatrician and Mariah's mother set health goals including OT, PT, psychosocial or subspecialty services that may be needed
- The pediatrician makes appropriate referrals



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TCM- Clinical Staff – 28 days

- RN meets with Mariah and her mother and assesses psychosocial needs
 - Mother is overwhelmed caring for Mariah
 - Provides information on local community resources that might be helpful
- RN collaborates with health services to support Mariah's goals and follow progress
- Mariah's mother prefers e-mail communication so RN emails weekly to encourage, review progress, answer questions, and address mother's concerns



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All 3 of the code's criteria must be met

- 99496 must include:
 - Contact within 2 business days
 - High complexity MDM
 - Visit within 7 calendar days
- Report 99495 if MDM is moderate complexity or face-to-face visit is within 8 – 14 calendar days from the date of discharge
- Do not report 99495-99496 if all 3 criteria are not met



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TCM points to remember

- Medication reconciliation and management must occur no later than date of the face-to-face visit
- Same physician can report discharge services and TCM if physician did not provide a service for which global period applies
- One individual reports once per patient within 30 days of discharge, cannot report again within 30 days (even if new admission/discharge)
- First physician to report TCM is paid, all others denied



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TCM documentation

- Physician/QHCP review of the discharge records including test results and follow-up on any pending tests or scheduled tests
- Date of initial post-discharge contact (and attempts) and context of communication
- Document patient's condition, psychosocial needs, support necessary for activities of daily living, other factors affecting care management (nature of presenting problems)
- Document and date medication reconciliation
- Document TCM non-face-to-face services listed in CPT (for Medicare- reason services were not necessary)
- Document face-to-face encounter with specified time period for code
- Include legible signatures and credentials of physician, QHP's and licensed clinical staff



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TCM: Services not reported separately include:

- Care plan oversight (99339, 99340, 99374-78)
- Prolonged services without patient contact (99358-99359)
- Medical team conferences (99366-99368)
- Education and training (98960-98962, 99071, 99078)
- Telephone services (98966-98968, 99441-99443)
- Online medical evaluation (98969, 99444)
- Preparation of special reports (99080)
- Analysis of data (99090, 99091)
- Complex chronic care coordination (99487-99489)
- Medication therapy management services (99605-99607)
- ESRD services (90951-90970)



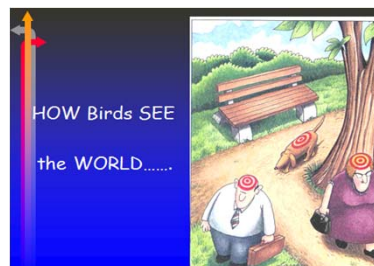
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Quick Review: Avoid Fraud & Abuse



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Compliance and the Importance of Correct Coding



Thanks for slides, Joell!

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Federal Fraud and Abuse Laws

- ✓ **False Claims Act**
(31 USC 3729)
 - ✓ **Anti-Kickback Act**
(42 USC 1320a-7b(b))
 - ✓ **Stark Laws**
(42 USC 1395 nn & nn(h)(6))
 - ✓ **Exclusion Statute** [42 U.S.C. § 1320a-7]
 - ✓ **Civil Monetary Penalties Law** [42 U.S.C. § 1320a-7a]
- ✓ These laws are upheld through a nationwide network of audits, investigations & inspections



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Pediatricians and Risk

- High rates of participation in government programs- Medicaid, CHIP, TriCare
- High rate of E/M billings- complex coding rules
- Many pediatricians do not know CMS rules or have compliance programs
- Now joining larger groups- may "inherit" compliance risk



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Health Care Fraud

- Health care fraud is defined as the **intentional deception or misrepresentation** made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person.



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Health Care Waste

- Waste is deemed to occur when services rendered are not cost effective.
- **Continual ordering of services which are not medically necessary**
e.g. (signing home health orders for nursing services, or signing orders for DME – orders or letter of medical necessity often written by the company)



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Health Care - Abuse

- Abuse is any provider practice that is inconsistent with sound fiscal, business or medical practices and results in unnecessary costs to a health care program or in **reimbursement of services that were not medically necessary or failed to meet the standard of care.**



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Coding & Billing Areas of Risk

- E/M upcoding - 99214-99215
- Afterhours Care- billing add-ons incorrectly
- Unbundling of comprehensive services- overuse of modifiers which break CCI edits
- Billing services during a global period
- Failure to document time in using time based codes
- Billing for "New" patients who are by definition established in the practice
- Billing 90461 to VFC, or using 90460/90461 when the MD does not counsel



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Fraud and Abuse Detection

- Pattern of billing more office visits or procedures than similar peers in same locality
- Pattern of consistently higher levels of E/M codes than peers
- Complaints from patients or others indicating services billed were never provided



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Fraud and Abuse: Origins of Investigation

- Complaint from a irate patient, spouse, ex-spouse, or a competitor
- Receipt of an altered bill
- Receipt for claim for services rendered after a patient's death
- Inappropriate billing of supplies
- Aberrant utilization patterns



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The RAC- Don't Get Caught...



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RAC: Recovery Audit Contractor Program

- In 2006, the Tax Relief and Health Care Act made permanent the Medicare Recovery Audit Contractor (RAC) program for identifying improper Medicare payments in all 50 states.
- The Affordable Care Act required state Medicaid programs to hire RAC contractors to audit payments, effective 12/31/2010.
 - The RAC program will apply to physician Medicaid payments.
- **Who are RAC's?**
 - RAC's are private auditing firms contracted by the Centers for Medicare & Medicaid Services (CMS)- paid on a contingency fee basis- that use sophisticated claims data analytics to recognize improper payments, aberrant trends and inappropriate utilization.
 - RACs may review the three preceding years of a provider's claims and review medical records (per contract and state insurance laws).



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The Bad News- How Is it Delivered?

- Request for Records- the payment audit
 - Request by payer for medical records of given patient to review documentation of coding on claims which were flagged in an audit
- Recovery Letter- the request for money
 - Request for money- based on a claims review using sophisticated algorithms you have incorrectly submitted claims for a number of patients amounting to \$xxxxx



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How to Minimize Audit Exposure

- Communicate effectively with patients about the treatment provided/tests ordered.
- Keep detailed and legible records.
- All ICD and CPT codes billed diagnoses on claims should be documented in the medical record and reflect the medical necessity and service provided.
- Review all billing and coding rejections and denials as they are received
- Maintain high level of competency among billing and coding personnel



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Minimizing Audit Exposure (con't)

- If using a billing service, monitor them as you would your own staff
- Be wary of coding/billing advice from manufacturers
- Conduct random, internal self-audits on billing and coding procedures
- Develop/maintain Compliance Programs



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Compliance Programs

- A comprehensive set of policies and procedures, along with a method of independent verification, to ensure that all applicable laws regulations, and rules of an organization are followed. (i.e. a proactive method to prevent, detect and rectify improper practices)



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Compliance Programs

- Create an environment in which rules must be followed and which reduces incentives to "cheat the system"
 - Ensures claims submitted are accurate
 - Ensures that fraudulent behavior does not occur/recur
 - Reduces criminal and civil wrongdoing
 - Mitigates administrative liability



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AAP Coding Resources

- NEW! Coding At the AAP Site
 - One stop shop for all coding related resources from the AAP!
- AAP Coding Hotline
 - aapcodinghotline@aap.org



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AAP Pediatric Coding Publications

AAP Pediatric Coding Newsletter™

Stay current with all the latest in pediatric coding and compliance.

Coding for Pediatrics, 2014

Published annually, this signature coding publication complements standard coding manuals with proven pediatric-specific documentation and billing solutions.

Pediatric Code Crosswalk ICD-9-CM to ICD-10-CM

Simplify ICD-9-CM coding AND prepare for ICD-10-CM transition!

Principles of Pediatric ICD-10-CM Coding

A practical desktop handbook and an efficient training tool, it provides a wealth of pediatric-focused knowledge for accurate diagnosis coding.

Special Coding Webinar Registrant Offer - SAVE 20%!
Order online at www.aap.org/bookstore and apply
Promo Code **BFWEB** at checkout to receive the 20% discount.
Offer expires on December 13, 2013.



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New Resource from the AAP

- Interactive Periodicity Schedule
- Allows you to click on a particular encounter (eg, 2-month; 12-month) and it will link you to a resource that outlines all the recommended services and appropriate codes for those services if separately reportable.
- Links to Red Book online, vaccine schedules, catchup schedules and vaccine coding table.
- Available soon...



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AAP Coding Resources

- Private Payer Advocacy Letters
- Use to appeal denials when services are rendered and properly coded for
 - Well-Sick (Same day)
 - Denials for vision, hearing or developmental screening
 - Payers that require modifier 25 when reporting vaccines
 - Reporting 99211 for PPD readings
- Contact the AAP Coding Hotline for a copy of any of the above aapcodinghotline@aap.org



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Private Payer Advocacy

• PPA For Preventive Care

- Engage private payer support of the pediatric medical home & Bright Futures Guidelines for preventive care
- Letter to national carriers informing of AAP BF recommendations/Periodicity Schedule
- Talking points for AAP chapter pediatric councils for discussions with payers
- When new recommendations are released, the AAP's Private Payer Advocacy Advisory Committee works with payers on coverage.



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Questions & discussion



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