Take a Deep Breath:
Coding to Improve Asthma Care and Reimbursement

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CME Accreditation

- This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of The George Washington University School of Medicine and Health Sciences and Children's National Medical Center. The George Washington University School of Medicine and Health Sciences is accredited by the ACCME to provide continuing medical education for physicians.

- **PHYSICIAN CME CREDIT**

- The George Washington University School of Medicine and Health Sciences designates this continuing medical education activity for a maximum of **1** AMA Physician Recognition Award Category 1 Credit™.

Faculty disclosures

- No conflicts of interest

Today's learning objectives

- At the conclusion of this presentation, attendees will be able to:
  - Describe best coding practices for asthma care and reimbursement
  - Develop a gameplan for implementing improved documentation and coding into your practice setting
  - Describe strategies for identifying and improving care delivery and outcomes for all children with asthma in your practice

Coding to Improve Asthma Care & Reimbursement
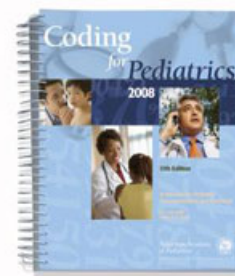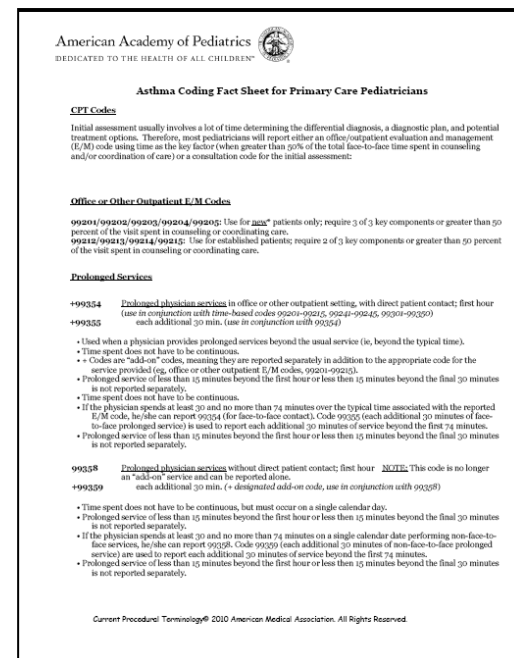

TAKE A
DEEP BREATH

Important legal qualifiers for coding webinar...

- **Antitrust violation** for independent competing practices to jointly discuss <u>fees</u> or related contracting activities
  - We <u>can</u> share "best practices" that maximize reimbursement & efficient practice management
  - Use RVU and CMS Medicare fee examples whenever possible
- Can not code or bill for services that were not provided & (clearly) documented
  - **Fraud & abuse penalties are severe**
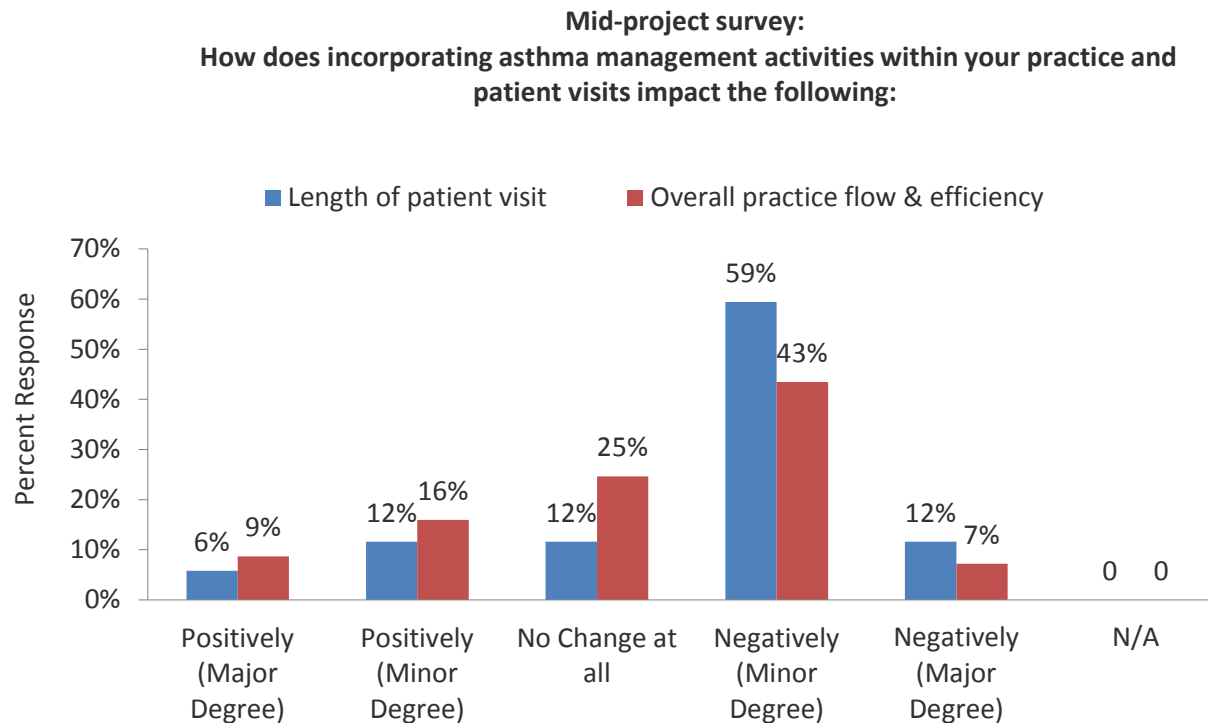 - No documentation = no appeal (no excuses)

Additional caveats & disclaimers

- Coding guidance reflects best practice recommendations from the American Academy of Pediatrics and other coding experts & resources
  - AAP Asthma Coding Fact Sheet for Primary Care Pediatricians
  - AAP Practice Management Online (PMO)
  - AAP *Coding for Pediatrics* 2013
  - AAP Section of Administration & Practice Management (SOAPM)- great list-serve
  - AAP Coding Hotline (aapcodinghotline@aap.org)
  - AAP National Center for Medical Home Implementation
- Coding recommendations are not represented as official legal guidance from Children's National Medical Center or Children's National Health Network
- Know your payers! Track your EOB's & denials.

Better asthma care often takes more time and practice resources- make it worth your while!

Mid-project survey:
How does incorporating asthma management activities within your practice and patient visits impact the following:

Legend: ■ Length of patient visit ■ Overall practice flow & efficiency

Category	Length of patient visit	Overall practice flow & efficiency
Positively (Major Degree)	6%	9%
Positively (Minor Degree)	12%	16%
No Change at all	12%	25%
Negatively (Minor Degree)	59%	43%
Negatively (Major Degree)	12%	7%
N/A	0	0

Y-axis: Percent Response (0% – 70%)

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Maximize coding basics for most ROI

- Understand and maximize **coding basics**
- Not all recommended coding practices are recognized by payers (CMS Medicare, local medicaid & commercial insurers)
- Not all services are covered benefits by all employers
- Monitor your EOB's & denials
- Challenge mistakes

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Asthma coding basics

AAP Asthma Coding Fact Sheet (attached)

- CPT Codes
- Office E/M Services
- Prolonged Services
- Procedures
- Non-Physician Services
- Health Risk Assessment
- Care Plan Oversight
- Special Services
- Supply Codes
- ICD9 Diagnosis Codes

Asthma Case Study 1: Spenser

- An established patient with known mild intermittent asthma presents to your practice during regular Saturday hours with a two day history of mild URI, low grade fever and gradual onset of increased coughing and mild wheezing. Parents are non-smokers but the child visited an uncle over weekend who is a smoker. Child has a history of late spring pollen sensitivity. Mother has been administering albuterol via inhaler with temporary relief.   She can't find her child's spacer. She recalls receiving a written asthma action plan last fall but would like another copy.

- You perform a detailed examination. Medical decision-making is moderately complex (acute exacerbation of a problem and prescription drug management).

- Your practice nurse observes technique and reviews inhaler and spacer use with the child and parent. The child responds well to two inhalation treatments in your practice. You refill the albuterol prescription and add a short course of oral prednisolone. You update and provide a copy of the written asthma action plan.

- You spend 20+ minutes face-to-face with child and parent- most of which was clarifying history and counseling. The child spends an additional 10 minutes with your nurse. You schedule a follow-up visit in 2-3 weeks to plan management for upcoming pollen season.

How would you code this visit?

- 99214-<u>25</u>
- 99051
- 94761
- 94664-<u>59</u>
- 94640
- Supplies

- Office E&M service
- Care during extended office hours
- Pulse oximetry, multiple* (usu. bundled)
- Nurse education of MDI use**
- Inhalation treatment (nebulizer or MDI)
- (J7611-J7620)

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94644: Demonstration and/or evaluation of patient use of nebulizer, MDI

- **94644** (continuous inhalation treatment with aerosol medication for acute airway obstruction, first hour)

- **94664** (demonstration and/or evaluation of patient utilization of aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing device) is reported with modifier **59.**

  - The services may be reported when performed as incident to the physician's services (ie, physician is in the office and available to provide assistance or direction).

  - The Medicare National Correct Coding Initiative (NCCI) edits pair code **94664** with code **94640** (inhalation treatment for acute airway obstruction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing device) but allows both services to be reported when they are clinically indicated and modifier **59** (distinct procedural service) is appended to code **94664.**

- (AAP Coding Newsletter)

Asthma Case Study 2: Jalen

- An established patient is seen immediately on arrival in the office with complaints of shortness of breath and wheezing that started in the middle of the day and have progressed in severity without relief from treatments performed at home.

- A detailed history and examination are performed. The physical examination shows a child in acute distress with bilateral wheezes, poor air movement, and hypoxia.

- He is given a continuous nebulizer treatment with albuterol over a period of 90 minutes. An assessment is performed every 15 minutes. After 90 minutes, he is improved. Before he is sent home, the nurse evaluates his use of the nebulizer.

- *(AAP Pediatric Coding Newsletter Online June 2010)*

How would you code this visit?

- 99214-<u>25</u>
- 99058
- 94761
- 94644
- 94664-<u>59</u>
- 94640
- Supplies

- Office E&M service
- Emergency care disrupting office care
- Pulse oximetry, multiple* (usu. bundled)
- Continuous inhalation Rx, 1st hour
- Nurse education of MDI use**
- Inhalation treatment (nebulizer or MDI)
- (J7611-J7620)

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Continuous inhalation treatment (AAP)

- Note the following guidelines when reporting continuous inhalation treatment:
  - Services reported with codes **94644** and **94645** differ from the services described in code **94640.**
  - Continuous inhalation treatment is administered over long periods and then discontinued, a higher dosage of medication is administered, and different equipment is used to administer the treatment. Code **94640** is used to report the administration of short treatments and those that are usually administered several times a day.
  - Code **94644** is reported for each hour of continuous inhalation therapy with aerosol medication.
  - Code **94645** may be reported for each additional hour of continuous inhalation treatment.
  - Services of less than 1 hour are reported with code **94640.**
  - The NCCI edits pair code **94640** and **94644.** The edit is assigned a **0** modifier indicator not allowing override with a modifier.

Coding for after hours services

- Modifiers *in addition* to basic service
- 99050   Services provided in office outside regularly scheduled hours or on holidays
- 99051   Services provided during regularly scheduled evening & weekend hours
- 99058   Services provided on an emergency basis in the office, which disrupts other scheduled office services
  - Not simply fitting patient in schedule

Case Study 3: Kyle (Preventive Care)

- You see an established 7 year old patient for a scheduled well child visit. The child has a history of mild intermittent asthma. The parent notes increasing coughing at night and with exercise. She uses an albuterol MDI with spacer several times a week. The father smokes occasionally but only outside the house. The child received influenza vaccine last fall.

- You perform and document a comprehensive preventive care exam. You have the parent complete an asthma control test. You additionally review and document asthma history, severity, control, triggers. You spend an additional 15 minutes reviewing asthma management.

- Based on increasing symptoms, you recommend a controller medication for increasing/persistent asthma symptoms. You develop and review a written asthma action plan with the mother and provide smoking cessation information for the father. Your office nurse reviews inhaled corticosteroid MDI/spacer use & technique with the mother and child.

- You recommend a follow up visit in 6-8 weeks to re-assess control.

How would you code this visit?

- 99393
- 99213-<u>25</u>
- 94664

- Preventive care, (age 5 – 11 years)
- Office E&M service
- Nurse education of MDI use**

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.

- Code **V15.89** (other specified personal history presenting hazards to health, other exposure) can be reported in addition to asthma (**493.xx**) because that risk may affect the child's health.

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98960-98962:
Education and Training for Patient Self-Management

- If a practitioner has created a training curriculum for educating patients on management of their medical condition, he or she may employ a nonphysician health care professional to provide education using a standardized curriculum for patients with that disease.
  - The curriculum may be modified as necessary based on the patient's clinical needs or the patient or caregiver's cultural norms and health literacy.
  - These services are used to teach the patient or caregiver how to effectively manage the illness(es) or condition(s) or delay disease comorbidity(ies) in conjunction with the professional health care team.
  - They are reported based on the total face-to-face time (each 30 minutes) and the number of patients receiving the education and training.
- *CPT* code **98960** is reported for each 30 minutes of education and training provided to an individual patient; code **98961** is reported when they are provided to 2 to 4 patients; and code **98962** is reported when 5 to 8 patients receive them.
- For example, if a physician has a large number of asthmatic patients in the practice, the use of a standardized curriculum emphasizing the importance of peak flow monitoring, use of preventive medications, and avoidance of overuse of rescue medications should improve patient compliance and safety for this chronic illness.

S9441

- 2012 HCPCS S Code
- Asthma education, nonphysician provider (NPP); per session
- Not payable by Medicare

- National Asthma Educator Certification Board
  - www.naecb.com

Coding Pearls: The Preventive Medicine Code

"If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and **if the problem/abnormality is significant enough to require additional work** to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code **99201-99215 should** also be reported.

Modifier 25 should be **added to the Office/Outpatient code** to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported. "

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The Coding Pearls: The Modifier -25

- The modifier ALWAYS goes on the E/M code

- When a Preventive Medicine code and an E/M office visit for a problem are billed together, ALWAYS put the -25 on the non-preventive E/M code

- Never attach the -25 to a non-E/M code

Coding Pearls: The Modifier -25

- When a separate problem is evaluated and reported with a NEW preventive medicine service-

- Use the NEW OV/Outpatient codes 99201-99205

Coding Pearls: The Modifier -25 (Sick + Well)

What is Significant?

- A separate visit would have been required to take care of the problem

- A problem requires an RX to treat

Coding Pearls: The Modifier -25 (Sick + Well)

What is Separate?

- Additional documentation is needed

- Separate documentation helps you select the correct E/M code level

  - Additional History, PE, MDM

- Separate documentation also helps you with an audit-

  - keeps auditors happier- just like legible writing

What degree of documentation is recommended?

- Documentation should support added service (Hx, PE, MDM, counseling, time)
  - Could it billed as "stand alone" visit?
- One note vs two notes?
  - Document so added care is clear

Office or Other Outpatient Services- Established Patient

Document either **2 or 3 key components** (history, examination, & medical decision making) OR
time spent counseling the patient

	99211	99212	99213	99214	99215
History					
Level of History	**No 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 Exam	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 9 systems
Medical Decision Making					
Level of MDM	Not Required	Straightforward	Low	Moderate	High
Face-To-Face Time					
Typical Times	5 minutes supervision*	10 minutes	15 minutes	25 minutes	40 minutes
Relative value units/ 2013 Medicare payment Conversion Factor= $34.023					
Total Rvu/ $	0.60/$20.41	1.29/$43.89	1.46/$72.47	2.25/$106.49	3.17/$142.90

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•physician must be in the office during the E/M service

Coding based on Time

- An explicit factor to assist in selecting the most appropriate level of E/M services

- ***When counseling and/or coordination of care are more than <u>50%</u> of the face to face encounter, time is the key controlling factor***.

- Documentation of time in the medical record is a must in this situation

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Counseling

- Discussion with a patient <u>and/or</u> family concerning

  - Diagnostic studies or results

  - Prognosis

  - Risks and benefits of management options

  - Importance of compliance

  - Patient and family education

Typical Times for Outpatient Services

- 99211   5 min.
- 99212   10 min.
- 99213   15 min.
- 99214   25 min.
- 99215   40 min.

- 99201   10 min.
- 99202   20 min.
- 99203   30 min.
- 99204   45 min.
- 99205   60 min.

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What about "sick & well" co-pays?

- Health Care Reform: no co-pays for preventive care services (including well-child exams)
- Several plans now requiring patient co-pays if E&M service (-25 modifier) billed on same DOS
  - For asthma, obesity or any other significant concern
- Families confused/angry; office staff under fire

Strategies

- Share office policy in advance?

- Hand-outs or signs in practice waiting area, website

- What should be included in message?

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 children have extra concerns about their health or behavior that require extra time and 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.

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Other key modifiers

- -25   Significant separately identifiable E/M Service, same physician, same day
- -59   Distinct procedural service
- -76   Repeat procedure by same physician

Modifier 25

- Significant separately identifiable E/M service, same physician, same day

- If additional E/M services are provided at the time of a procedure, code the E/M service with modifier 25 along with the procedure code

  - Example: Problem-focused encounter with a nebulizer treatment

  - **99213-25** Level 3 E/M service

  - **94640** Nebulizer Treatment

Modifier 59

- An asthmatic patient presents with wheezing. You perform a moderately complex E/M service. You administer a neb and you work with the patient on the proper use of their MDI.

  - **99214 25**
  - **94640**
  - **94664 59**

Modifier 76

- Use when the same physician has to repeat the same procedure to alert the payer not to deny as duplicate
- Example: A patient with severe wheezing does not respond well to an initial neb treatment. The physician determines another one needs to be complete.
  - **94640** with modifier 76 and 2 units
  - OR
  - **94640**
  - **94640 76**

Common ICD-9-CM Codes

- 493.00 Extrinsic asthma; unspecified
- 493.01 Extrinsic asthma; with status asthmaticus
- 493.02 Extrinsic asthma; with (acute) exacerbation
- 493.10 Intrinsic asthma; unspecified
- 493.11 Intrinsic asthma; with status asthmaticus
- 493.12 Intrinsic asthma; with (acute) exacerbation
- 493.20 Chronic obstructive asthma; unspecified
- 493.21 Chronic obstructive asthma; with status asthmaticus
- 493.22 Chronic obstructive asthma; with (acute) exacerbation

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Common ICD-9-CM Codes

- 493.81 Exercise induced bronchospasm

- 493.82 Cough variant asthma

- 493.90 Asthma, unspecified (Bronchitis: allergic, asthmatic); unspecified

- 493.91 Asthma, unspecified (Bronchitis: allergic, asthmatic); with status asthmaticus

- 493.92 Asthma, unspecified (Bronchitis: allergic, asthmatic); with (acute) exacerbation

- 786.05 Shortness of breath

- 786.07 Wheezing

- E869.4 Exposure to second hand smoke*

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Asthma & ICD-10-CM

- Implementation postponed until October 2014
- Significant changes to the ICD-10-CM nomenclature regarding asthma
- Now can code based on severity (mild, moderate, severe)
- Now can code intermittent versus persistent

ICD-10-CM

- Acute bronchospasm (J98.01)
- Asthma
- J45.20 Mild intermittent, uncomplicated
- J45.21 Mild intermittent with (acute) exacerbation
- J45.22 Mild intermittent with status asthmaticus
- J45.30 Mild persistent, uncomplicated
- J45.31 Mild persistent with (acute) exacerbation
- J45.32 Mild persistent with status asthmaticus
- J45.40 Moderate persistent, uncomplicated
- J45.41 Moderate persistent with (acute) exacerbation
- J45.42 Moderate persistent with status asthmaticus

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ICD-10-CM: Asthma (continued)

- J45.50 Severe persistent, uncomplicated
- J45.51 Severe persistent with (acute) exacerbation
- J45.52 Severe persistent with status asthmaticus
- J45.901 Unspecified asthma with (acute) exacerbation
- J45.902 Unspecified asthma with status asthmaticus
- J45.909 Unspecified asthma, uncomplicated
- J45.990 Exercise induced bronchospasm
- J45.991 Cough variant asthma

Procedures

- 94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

- 94014 Patient initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation

- 94015 Patient initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration

- 94016 Patient initiated spirometric recording per 30-day period of time; physician review and interpretation only

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- 94060 Bronchodilation responsiveness, spirometry, as in 94010, pre and post-bronchodilator administration NOTE: Does include the bronchodilation

- 94150 Vital capacity, total (separate procedure) Note: requires hookup to spirometer

- 94640 Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum indication for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)

- 94644 Continuous inhalation treatment with aerosol medical for acute airway obstruction; first hour (for less than an hour report 94640)

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- 94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device.

- 94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination

- 94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations

Procedures with no CPT code

- Administration of oxygen
  - However, can code for supplies such as tubing (A4616), mask (A7015)
- Peak Flow Meter (Hand held)
  - Alternative HCPCS code (S8110 Peak expiratory flow rate (physician services)

Supplies & medications

- Remember: If a payer follows RBRVS when valuing codes, most will not pay separately for mouthpiece and tubing, but should always pay for medications:

  - **J7611** Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1mg (Albuterol Sulfate, Proventil,
  - Ventolin)
  - **J7612** Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 0.5mg (Xopenex)
  - **J7613** Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1mg (Albuterol Sulfate, Proventil, Accuneb)
  - **J7614** Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 0.5mg (Xopenex)
  - **J7626** Budesonide inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, up to 0.5mg (Pulmicort Respules, non-compounded, concentrated)

Asthma quality measures

Asthma quality measures: HEDIS & MU

2014 Clinical Quality Measures (CQMs)
Pediatric Recommended Core Measures

CMS eMeasure ID & CQM Number	CQM Title & Description	Measure Steward & Contact Information	Other Quality Measure Programs that use the Same CQM	Domain
CMS126v1 NQF 0036	**Use of Appropriate Medications for Asthma** Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.	NCQA: www.ncqa.org	EHR PQRS	Clinical Process/ Effectiveness

Public Reporting of Asthma Care

Childhood Asthma

Childhood Asthma

How will your practice score?

CNHN Asthma QI Learning Collaborative
MOC Project Measures

	Severity Documented	Control Assessed	ICS Prescribed	Triggers Assessed/ addressed	A Follow-up Documented	Current Asthma Action Plan
Baseline '12	50%	67%	77%	45%	62%	25%
November	79%	84%	87%	70%	82%	50%
December	87%	82%	95%	66%	85%	57%
January `13	87%	87%	95%	70%	88%	57%
February	90%	92%	93%	76%	91%	68%
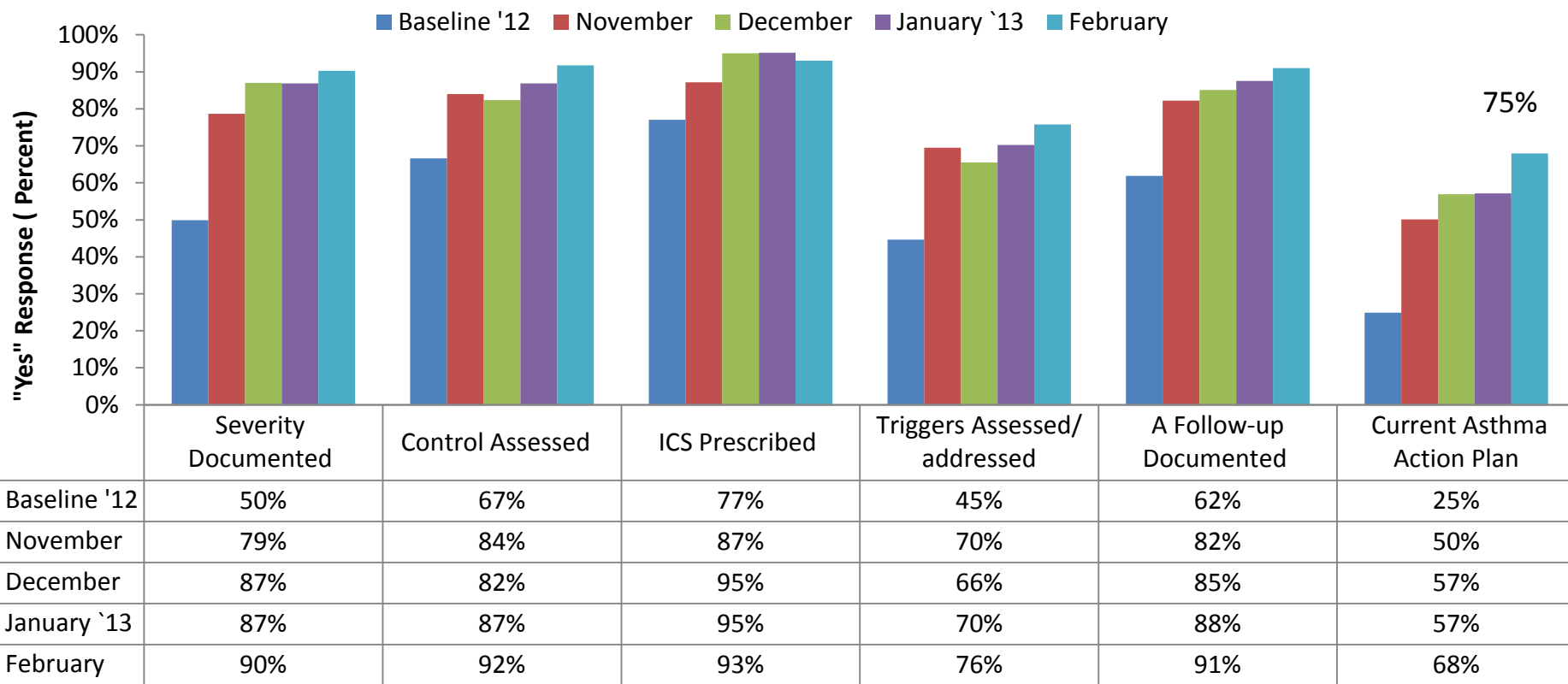
Project Measures

Population care: All children in your practice

Chart audit ⇨ Population focus

- Think about *__all__ patients in your practice with [asthma]*
  - Attributed as PCP (primary care provider)
- Manage preventive care, chronic illness and coordinate care for all attributed patients ⇨ better satisfaction, better quality outcomes, lower total healthcare expense ("Triple Aim")
- Major payers profile claims (primary care, UC, ED, hospital, DME) & pharmacy/prescription data for each PCP/practice
  - HEDIS: controller medication for persistent asthma; use of controller meds (50%, 75% of expected)
  - COST: asthma ED/hospitalization is expensive

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Asthma population management

- Identify & manage all children with asthma in your practice
  - ICD-9: 493.xx in claims, EMR problem list/assessments
  - Who has had an office visit in past 3, 6, 12 months?
  - Who has been to ED or hospitalized for asthma? (RED FLAG)
    - Planned asthma visit, written asthma action plan, scheduled follow-up
    - Specialty referral if appropriate
    - MCO case management/care coordination
  - Patient outreach = better care, better use of Medical Home, lower use of expensive alternatives, higher patient satisfaction

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Children's National: Pollen busters pilot

- Identify all patients seen previous spring for:
  - Asthma (493.xx), allergic rhinitis (477.xx), allergic conjunctivitis (372.14), office nebulizer treatment (CPT 94640)

- Contact (direct mail; electronic: email or text, phone) and:
  - Offer office appointment <u>before</u> symptoms
  - Refill prescriptions if appropriate
  - If recent visit, current asthma action plan- reminder re: controller meds, allergy meds as appropriate, trigger avoidance

- Goals: proactive management; improved family satisfaction; reduced urgent care/ED/hospitalization use/expense; increased utilization of Medical Home

Secrets to success…

Medical Home success: shift asthma from episodic care to on-going coordinated care

- Document and bill for extended E&M services (time)

- Use modifiers (-25, -59) to indicate more than one service provided

- With family knowledge, incorporate asthma management into preventive care visits- bill for both on same DOS

- Do more planned asthma visits: plan regular follow-up visits to manage chronic illness

- Extended hours (99051 modifier) (enhance payments and reduce ED/UC convenience care = better Medical Home payments)

- Do asthma outreach & population management
  - Frequent ED visits & admissions (see in Medical Home or refer to asthma specialist, MCO care coordinator/case manager or both)
  - Seasonal planning (pollen & triggers)

Questions & discussion