Value Based Coding- Turning Knowledge to Payment!

20th CNHN Pediatric Practice Management Seminar
Wednesday December 6, 2017 11 AM
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Faculty Disclosure Information

In the past 12 months, we have no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in this CME activity.

I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.
**Learning Objectives**

- Based on this presentation, changes you may wish to make in practice:
  - Beginning 1 Jan.- Use the key coding updates for 2018
  - Apply new knowledge about coding and payment to further your success in Value based payment programs
  - Learn how you can consider new care models built on concepts of population health and team based care
**Terminology for “Getting Paid”**

**Reporting:**
- the “billing” of CPT codes to a payer for services rendered so they can be paid or tracked (entered into a database)

**Licensure:**
- a state entity allowing the provider to perform a service under a “scope of practice” law, act, or regulation

**Credentialing:**
- certification by a public or private payer defining the services for which the provider will be paid
CURRENT PROCEDURAL TERMINOLOGY (CPT)

- Copyrighted publication by the AMA
- Used as the standard Medicare code set since 1990’s
- Tell payers **what service** was performed by a physician on a given patient on a given date
- Provides common definitions for physician work based on
  - Nature and amount of work
  - Place and type of service
  - Patient’s health and age (in some cases)
CPT Code Categories

**Category I:**

- Most commonly used codes for billing for patients services-numeric

**Category II:**

- Performance improvement or tracking codes pay for performance (P4P) measures
- Alphanumeric

**Category III:**

- New procedures and technology
- Can be used for payment, alphanumeric
ICD-10-CM

– Published by the World Health Organization for epidemiological tracking of illness and injury
– The clinical modification in the US is controlled by the ‘cooperating parties’
  ▪ CMS
  ▪ National Center for Health Statistics/CDC
  ▪ American Hospital Association
  ▪ American Health Information Management Association
– Tells Payers about the **Medical Necessity** of services-the “**WHY**”
**Payment**—The Medicare Physician Fee Schedule

**Resource Based Relative Value System (RBRVS)**

- Is updated each year by CMS in October -November Federal Register – “Final Rule”
- Is used by the majority of private and public payers (CMS by Year)
- Most CPT codes have a relative value unit - “RVU”
- Each year an updated conversion factor is published- 2015 Payment- rvu x cf
RBRVS EXPLAINED

- 2018 -conversion factor = $35.99
- Payment Example-

99213- office visit

  RVU = 2.06
  CF= $35.99

- So Fee= 2.06 x $35.99 = $74.14
THE REVENUE CYCLE (GETTING PAID)

- Provide the services
- Find the correct billing codes
- Assign your fee to each service billed
- Report (Bill) the claim
- Receive your EOB (explanation of benefit) with payment
- Review EOB, inform your coding practice, and appeal denials

(AND NEW)

Participate and succeed in Pay for Value programs
Why Code Correctly? The List Grows!!

• That’s how you get paid for clinical activity (service-code-claim-$)
• There is compliance risk if you don’t- fraud, waste, abuse
• “Narrow” or Tiered Payer Networks will have fewer providers overall, but more “higher value” providers
• There is a rapidly evolving alternative payment landscape- Value Based Payment- often additive to your fee schedule (P4P)
"The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these three aims separate. Society, on the other hand, needs these three aims optimized (given appropriate weightings on the components) simultaneously."

Tom Nolan, PhD, Don Berwick, MD, MPH

"The Triple Aim: Care, Health, And Cost," *Health Affairs*, 27, no.3 (2008): 759-769. Donald M. Berwick, Thomas W. Nolan and John Whittington,

"The Triple Aim: Care, Health, And Cost," *Health Affairs*, 27, no.3 (2008): 759-769. Donald M. Berwick, Thomas W. Nolan and John Whittington,
A New Quality-Through the Lens of the Triple Aim

• Ability to **reduce variation** in outcomes including cost

• Ability to provide **access** allowing “right care, right time, and right place”- afterhours and walk-in (patient centric)

• Ability and performance in closing “Care Gaps”- claim analytics- look at **evidenced based care** that has **not** been delivered

• **Member Experience**- patient activation, shared decision making, and navigation
**The New Lexicon – of Health Care**

- The Triple Aim
- Accountable Care
- The Value Equation for Health Care
- Value Based Contracting
- Value based insurance product design
- The New Quality
- Population Health
- Care Opportunities
- Variation
- Transparency
- Episodes of Care
- Patient Centered Medical Home
- Health Home for “Superutilizers”
- Narrow Networks
Coding and Value Based Payment

- Bundled Payments - are composed of costs defined by CPT and ICD codes
- Quality metrics - most defined by ICD and CPT codes billed
- Risk adjustment for cost of your patient is based on ICD coding (medical complexity – my patients are sicker)
- Population health - stratification and care gaps defined by risk (coding, utilization, EBM)
CREATING VALUE IN YOUR PRACTICE

• The Triple Aim - Improving –
  – health care (delivery- eg PCMH)
  – quality of care (outcomes- eg NCQA Measures)
  – the cost of care (right care ,right time, and right place)

• Creating Value \hspace{1cm} Value = Quality / Cost

• Payment follows Value
Tiering - A Triple Aim "Valuegram"
POPULATION HEALTH IS KEY

- Once you see your population, you will see the needs and design a better care model-

1. “See” your population- data analysis (claims, HRA, clinical )- risk stratified by risk or medical complexity (well, some risk, high risk)

2. “See” the needs of your population – “care opportunities”

   1. All get Bright Futures (well care, screening, vaccines)
   2. Those with Risk get more intense levels of care- care coordination/care management, transitional care
POPULATION HEALTH IS KEY

• Once you see your population, you will see the needs and design a better care model- the 3 “Rights”

• Right care- evidenced based/informed/clinical guidelines –
  – Bright Futures
  – CDC- ACIP Vaccine Schedule

1. Right place- in the Medical Home/Office- ACCESS

2. Right time – preventive approach- proactive vs reactive care
Population Health is Key

- Once you see your population, you will see the needs and design a better care model- the “right care, right place, right time” model

1. Your Three Populations-
   - They come for all care- and they love you (highly engaged)
   - They come for acute care if convenient- they like you- mild-mod. engagement)
   - They don’t come to your office- use ER. retail./urgent care

2. Develop Models- include both “outreach” and “in-reach” to close care gaps and provide access to evidenced based pediatrics

3. The Value ($)-
   1. Close care gaps = High Quality (HEDIS/EPSDT)
   2. Right care, place time = Cost savings (share savings)
NEW CARE MODELS THAT IMPROVE THE CARE

- Integrated care models- develop the “integrated care plan” define medical behavioral and social needs in your population, and deliver on the care and the social solutions
  - barriers to both quality and cost savings (value) are rooted in behavioral conditions – depression, schizophrenia, bipolar, substance use- must address BEFORE medical needs are met
  - or social determinants – food, shelter, and transportation come before medical care

- Patient “engagement or activation”
  1. Measure “engagement” in those with risk or non compliance- tools exist – the new science of compliance
  2. Brings need for Team Care – high touch, collaborative, family centered
Defining Team Based Care Attributes

- Care allows pediatricians to connect with their patients on key clinical issues and provide comprehensive, continuous, coordinated care by involving more of the practice staff in patient care as appropriate to their training and capabilities. Team-based care can also increase a practice's efficiency and productivity.
- Care that engages a greater number of staff in patient care and affords physicians, as the leader of a practice team, additional time to listen, think deeply, and develop relationships with patients and their families.
- Care that is highly informed- Team members are aware of the health history, status, and unique needs of the patient and family, and are assigned different responsibilities, which together are designed to result in continuous, comprehensive, coordinated care during and between visits. Team members feel engaged in their key role of caring for the patient. THE HUDDE
CSHCN –Children with Special Health Care Needs

- 13% of the pediatric population comprises children who meet the Maternal Child Health Bureau definition of special health care needs.

- **CSHCN (13%) account for 70% of pediatric health care expenditures.**

- Children with Medical Complexity, a subset of this population, are characterized by high service need, medical conditions associated with medical complexity, functional limitations, and high health care use.

Sadof et al, Clinical Pediatrics 1014; 1-5.
NEWER PAYMENT MODELS — EVOLVING RISK

- **Enhanced Fee for Service**
  - Typically higher rates than “non” PCMH
  - Payment policy (afterhours care, care plan oversight)
  - Evolution to risk — capitation

- **Prospective Payments- funding infrastructure**
  - Care coordination
  - EHR
  - NCQA certification costs
  - Evolution to risk based on outcomes

- **Retrospective Payments- For Performance or Value (new)**
  - Quality Indicators
  - Patient experience
  - Evolution to risk based on a Gain Share
**Retrospective Payments:**
**Pay for Performance or Value**

- Payment in addition to the Fee schedule
- Based on “performance” on certain agreed upon measures
- Program designed by payer(s)
- Comes as an amendment or attachment to the payer contract
- May involve a continuum of risk
PAY FOR PERFORMANCE: EVOLUTION
NEWER MODELS OF ACCOUNTABLE CARE

• **Gain Sharing** – (shared savings) a method for physicians and other providers to share in a defined way in **savings** a program generates for the population

  Gain share may be determined by –

  – Improvements compared to a past year(s) in chosen utilization metrics - ER, Inpatient
  
  – Improvements in Total Cost of Care (Medical Loss Ratios - MLR )
  
  – Meeting Quality Targets – the “Gate”
CONCEPT OF FINANCIAL RISK

- **Upside Risk** - you win- chance of getting a payment if performance targets are met or exceeded

- **Downside Risk** - you may not get a payment if targets are not met (even if you have resource costs in the effort), or in certain models you may lose payment by not hitting targets

- *Programs with downside risk typically have higher potential gains*
Pay for Performance or Value-Quality Measures

- Quality Indicators
  - Generally based on national guidelines and evidenced based measures
  - NCQA, NQF, Joint Commission (JCAHO), CMS develop measures
  - Can be reported on billing forms- CPT Category I and Category II codes, ICD codes, other (pharmacy)
  - Measured from claims (administrative), or chart review, or both (hybrid),
  - Can relate to a process or to an outcome
  - Payer will define the measures, the reporting, the targets, and the payments in the contract
HEDIS BASICS

• HEDIS = Healthcare Effectiveness Data and Information Set.
• Developed by the National Committee for Quality Assurance (NCQA) in 1993
• 90% of all health plans use HEDIS to measure performance, care, and service.
• HEDIS consists of 81 measures over 5 domains: Effectiveness of Care, Access/Availability, Experience of Care, Utilization & Relative Resource Use, & Health Plan Descriptive Information.
NCQA HEDIS Quality Measures

- Measure the **percent** of patients who have had or not had a given health intervention
- Measures have a **denominator** of the eligible patient population
- Measures have a **numerator** of the patients who have had the intervention
HEDIS 101

• Data for HEDIS is collected through surveys (CAHPS), medical chart reviews (hybrid metrics), and claims data (administrative metrics).

• HEDIS is one component of NCQA’s accreditation process.

• HEDIS measures are updated on an annual basis by NCQA to reflect the most current clinical practice guidelines/evidence based healthcare practices.
### 2015 Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure Steward</th>
<th>Measure Name</th>
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<tr>
<td></td>
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<td><strong>Access to Care</strong></td>
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<tr>
<td>NA</td>
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<td>Child and Adolescents’ Access to Primary Care Practitioners (CAP)</td>
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<td></td>
<td><strong>Preventive Care</strong></td>
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<td>0033</td>
<td>NCQA</td>
<td>Chlamydia Screening in Women (CHL)</td>
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<td>Childhood Immunization Status (CIS)</td>
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<td>NCQA</td>
<td>Well-Child Visits in the First 15 Months of Life (W15)</td>
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<td>NCQA</td>
<td>Immunizations for Adolescents (IMA)</td>
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<td>1448</td>
<td>OHSU</td>
<td>Developmental Screening in the First Three Years of Life (DEV)</td>
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<td>1516</td>
<td>NCQA</td>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)</td>
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<td>1959</td>
<td>NCQA</td>
<td>Human Papillomavirus Vaccine for Female Adolescents (HPV)</td>
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<tr>
<td>NA</td>
<td>NCQA</td>
<td>Adolescent Well-Care Visit (AWC)</td>
</tr>
</tbody>
</table>
NCQA Quality Measures

1. Appropriate Testing for Children With Pharyngitis (CWP) Ages 2-18 years
   - Diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode
   - Commercial, Medicaid (Admin.)

2. Appropriate Treatment for Children With Upper Respiratory Infection (URI) Ages 3 months–18 years
   - Given a diagnosis of URI and were NOT dispensed an antibiotic prescription.
   - Commercial, Medicaid
PEDIATRIC WELL CARE VISITS

Preventive service E&M

- Well Care Visits in the First 15 months of Life (W15)
- Well Care Visits in the 3rd, 4th, 5th and 6th years of Life (W34)
- Adolescent Well Care (AWC)*

- Exploit EHR documentation prompts & coding for well care coordinated compliance
  - BMI percentile, physical activity and nutritional counseling (WCC)
  - Completed, timely UTD immunization documentation (CIS/HPV/IMA)
  - Lead screening (LSC) - document date and result if in history*(ACC contract)
  - Chlamydia Screening (CHL) for sexually active 16-24 yo females

Important Points to Remember:
- Utilize age appropriate preventive service/health check CPT and ICD 10 codes
- Include age appropriate documentation supported ICD 10 codes for BMI and activity/nutrition counseling code
### Reporting CPT Cat 2 Codes

Codes Minimize record reviews for Hybrid Measures

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th>POS</th>
<th>TOS</th>
<th>Procedure</th>
<th>Diagnosis</th>
<th>Charges</th>
<th>Units</th>
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<tr>
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<td>11/07/2013</td>
<td>11</td>
<td>NCSV</td>
<td>0502F</td>
<td>V221</td>
<td>$0.01</td>
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| Consd Chg  | $0.01   | Deductible     | $0.00  | Discount Amount | $0.00 |
| Allowed Units | 0    | Copay          | $0.00  | Supplemental Discount | $0.00 |
| Allowed     | $0.00  | Coinsurance    | $0.00  | COB Adjustment   | $0.00 |
| Cons Allowed| $0.01  | Cons Benefit   | $0.01  |                  |       |
| Benefit     | $0.00  | Disallow       | $0.01  | Withhold         | $0.00 |
| HRA Paid    | $0.00  | Patient Liability Disallow | $0.00 |
| FSA Paid    | $0.00  | Total Patient Liability | $0.00 |

Provider Specialty: OBSTETRICS AND GYNECOLOGY

Procedure: Subsequent prenatal care visit. [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal

Add'l Modifiers

National Drug Code | NDC Units

Diagnosis: Supervision of Other Normal Pregnancy
HEDIS LINGO

• **HEDIS Care Opportunity = a “GAP” in Care**
  A HEDIS Care Opportunity means that there is an outstanding service for a patient, that once completed will result in member compliance for a particular HEDIS measure.

• **How are HEDIS Care Opportunities identified?**
  Health Plan identifies Care Opportunities through claims data following the HEDIS specifications for each measure. EHR’s can also identify Care Opportunities based on billings, age, etc –population health integration modules.

• **How are HEDIS Care Opportunities closed?**
  Care Opportunities are closed by completing the required service(s) for the identified members in the specified timeframe and submitting the appropriate codes for the service(s) provided.
New CPT for 2018

• Published in late September (new vaccine can be July or Jan on AMA website)
• Implementation under HIPAA is 1 Jan 2018

** Payers first see new codes and edits as above- new policy and pricing should be in effect by 1 January but check websites and contact payers for any high volume/revenue code changes
SUPPORTING BEHAVIORAL HEALTH INTEGRATION

• Behavioral Care integration with Physical Health
• Supporting evolving care models with 4 new CPT codes for psychiatric collaborative care and general behavioral care management.
• Evidence- better Adult care, higher quality and cost outcomes
• May be more defined than pediatric models
• Medicaid and Private Payers deciding coverage now- CMS covers both for Medicare
PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT (COCM)

- Three codes for TEAM based integrated care
  - 99492
  - 99493
  - 99494
- Reflects a New BH integration Care model
- Very Specific Requirements
- CMS covers- move from G codes to CPT 2018
PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT- REQUIREMENTS

- Services are provided under the direction of a treating physician or other qualified health care professional (QHP)
- Patient has a diagnosed psychiatric disorder that requires a behavioral health care assessment and establishing, implementing, revising, or monitoring a care plan; and provision of brief interventions
- Reported by the treating physician or other QHP
A physician or other qualified health care professional is an individual –
– who by education, training, licensure/regulation, and facility privileging (when applicable), performs a professional service within his/her scope of practice
– independently reports a professional service.
– **These professionals are distinct from ‘clinical staff.**

PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT- REQUIREMENTS

- Include the services of the treating physician or other QHP consultant who has contracted directly with the treating physician or other QHP, to provide consultation.

- Patients directed to the behavioral health care manager typically have newly diagnosed conditions, may need help in engaging in treatment, have not responded to standard care delivered in a non psychiatric setting, or.....

- Require further assessment and engagement, prior to consideration of referral to a psychiatric care setting.
DEFINING THE MODEL IN CPT
THE EPISODE OF CARE

• Begins when the patient is directed by the treating physician or other QHP to the behavioral health care manager

• Ends with attainment of targeted treatment goals, resulting in the discontinuation of care management services, OR failure to attain targeted treatment goals culminating in referral to a psychiatric care provider for ongoing treatment; or

• Lack of continued engagement with no psychiatric collaborative care management services provided over a consecutive six month calendar.
**Defining the Model in CPT**

**The Provider Definitions**

*Health care professionals* - the treating physician or other QHP who directs the behavioral health care manager and continues to oversee the patient’s care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.

- Evaluation and management (E/M) and other services may be reported separately by the same physician or other QHP during the same calendar month.
**Defining the Model in CPT**

**The provider Definitions**

*Behavioral health care manager* refers to clinical staff with a *masters-/doctoral-level education or specialized training in behavioral health who provides care management* services as well as an assessment of needs, including the administration of validated rating scales, the development of a care plan, provision of brief interventions, ongoing collaboration with the treating physician or other QHP, maintenance of a registry, all in consultation with a psychiatric consultant.

- Services are provided *both face-to-face and non-face-to-face* and *Psychiatric consultation is provided minimally on a weekly basis*, typically non-face to-face.
Initial psychiatric collaborative care management,

- first 70 minutes in the first calendar month of behavioral health care manager activities,
- in consultation with a psychiatric consultant, and
- directed by the treating physician or other qualified health care professional, with the following required elements:
PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

99492- Required elements:

• outreach to and engagement in treatment of a patient directed by the treating physician or QHP
• initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
• review by the psychiatric consultant with modifications of the plan if recommended;
• entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
• provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
99493

Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP
PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

99493- required elements:

• tracking patient follow-up and progress using the registry, with appropriate documentation;
• participation in weekly caseload consultation with the psychiatric consultant;
• ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;
• additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

99493- required elements:

- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- monitoring of patient outcomes using validated rating scales;
- relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

- 99494

Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)
## COCM- Medicare Fee Schedule

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<td>99492</td>
<td>G0502: initial PCCM ≥70 minutes per calendar month</td>
<td>3.98</td>
<td>$142.84</td>
</tr>
<tr>
<td>99493</td>
<td>G0503: subsequent PCCM ≥60 minutes per calendar month</td>
<td>3.52</td>
<td>$126.33</td>
</tr>
<tr>
<td>+99494</td>
<td>G0504: each additional 30 minutes</td>
<td>1.84</td>
<td>$66.04</td>
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CPT midpoint rule applies
#• 99484

Care management services for behavioral health conditions, at least **20 minutes of clinical staff time**, directed by a physician or other qualified health care professional, **per calendar month**

- Moved into CPT from HCPCS code G0507 with 2017 Medicare payment of $46.07
**Behavioral health Care Management**

**Required elements:**

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales.
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes.
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation.
- Continuity of care with a designated member of the care team
Behavioral Health Care Management

• Behavioral health integration care management (99484) and psychiatric collaborative care management (99492, 99493, 99494) may not be reported by the same professional in the same month.

• Behavioral health care integration clinical staff are not required to have qualifications that would permit them to separately report services (eg, psychotherapy), and ......

• If qualified and they perform such services, they may report such services separately, as long as the time of the service is not used in reporting 99484
Behavioral Health Care Management

• General behavioral health integration care management services (99484) are reported by the supervising physician or other qualified health care professional.
• The services are performed by clinical staff for a patient with a behavioral health (including substance use) condition that requires care management services (face-to-face or non-face-to-face) of 20 or more minutes in a calendar month.
• A treatment plan as well as the specified elements of the service description is required. The assessment and treatment plan is not required to be comprehensive and the office/practice is not required to have all the functions of chronic care management (99487, 99489, 99490).
• Code 99484 may be used in any outpatient setting, as long as the reporting professional has an ongoing relationship with the patient and clinical staff and as long as the clinical staff is available for face-to-face services with the patient.
EM Codes for Office and Hospital Care

- No major change for 2018
- CMS plan to revisit the EM Documentation guidelines
- Focus will be to increase the importance of the Medical Decision Making relative to the history and physical examination
- Although not a requirement (yet), consider MDM to the element that reflects the complexity of a given problem, and the drives the EM code selection. Learn the documentation requirement for this key element
ICD 10 CM
ICD-10-CM: NEW CODES FOR 2018

Clinical need → code development

The October 1, 2017 release is the culmination of 5 years worth of meetings/proposals


total ICD codes- 78,705
  – 3562 New codes
  – 1821 Revised codes
  – 645 deleted*

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
ICD 10 CM- 2018 ADDITIONS

Released July 2017 and implemented 1 October 2017- Highlights

- Umbilical granuloma will be reported with code P83.81, and P83.88 will be reported for other conditions such as bronze baby syndrome, neonatal scleroderma or urticaria neonatorum.
- Two new codes were added for reporting non-palpable testis (R39.83-R39.84).
- Acute respiratory distress will be specifically reported with code R06.03.
- Pediatric-specific criteria were added under the subcategories for coma scale for both best verbal response (R40.22-) and best motor response (R40.23-).
- Brief resolved unexplained event (BRUE) was added as an inclusion term under R68.13 (Apparent life threatening event in infant).
- Exercise counseling will be reported with code Z71.82, allowing use of claims data to track provision of exercise counseling in Healthcare Effectiveness Data and Information Set (HEDIS) or other quality measures.
ICD 10 CM- 2018 ADDITIONS

Released July 2017 and implemented 1 October 2017- Highlights Cont’d

• Picky eater was added as an inclusion term at code R63.3.
• 7th character (A,D,S) will be required for code T07 (Unspecified multiple injuries) as well as codes in category T14 (Injury of unspecified body region).
• New codes were added to further classify blindness and low vision.
• In remission was added for each substance in the mental health chapter to indicate when a patient with a former dependence is now in remission.
• New codes were added to both myocardial infarction and pulmonary hypertension.
• New codes were added for breast lumps
• Risk of dental caries may be specified as low, moderate, high or unspecified using codes Z91.841–Z91.849.
• External cause codes are added to category V86 to identify patients as driver, passenger or person injured while boarding or alighting from a dirt bike or all-terrain vehicle.
<table>
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<th>Description</th>
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<tr>
<td>F50.82</td>
<td>Avoidant/restrictive food intake disorder</td>
<td>R06.03</td>
<td>Acute respiratory distress</td>
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<tr>
<td>M33.03</td>
<td>Juvenile dermatomyositis without myopathy</td>
<td>R39.83</td>
<td>Unilateral non-palpable testicle</td>
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<tr>
<td>P29.30</td>
<td>Pulmonary hypertension of newborn</td>
<td>R39.84</td>
<td>Bilateral non-palpable testicles</td>
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<tr>
<td>P29.38</td>
<td>Other persistent fetal circulation</td>
<td>T07.XXX-(A,D,S)</td>
<td>Unspecified multiple injuries</td>
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<td>Gestational alloimmune liver disease</td>
<td>T14.8XX-(A,D,S)</td>
<td>Other injury of unspecified body region</td>
</tr>
<tr>
<td>P83.81</td>
<td>Umbilical granuloma</td>
<td>T14.90X-(A,D,S)</td>
<td>Injury, unspecified</td>
</tr>
<tr>
<td>P83.88</td>
<td>Other specified conditions of integument specific to newborn</td>
<td>T14.91X-(A,D,S)</td>
<td>Suicide attempt</td>
</tr>
<tr>
<td>P91.811</td>
<td>Neonatal encephalopathy in diseases classified elsewhere</td>
<td>Z71.82</td>
<td>Exercise counseling</td>
</tr>
<tr>
<td>P91.819</td>
<td>Neonatal encephalopathy, unspecified</td>
<td>Z91.841</td>
<td>Risk for dental caries, low</td>
</tr>
<tr>
<td>P91.88</td>
<td>Other specified disturbances of cerebral status of newborn</td>
<td>Z91.842</td>
<td>Risk for dental caries, moderate</td>
</tr>
<tr>
<td>Q53.111</td>
<td>Unilateral intraabdominal testis</td>
<td>Z91.843</td>
<td>Risk for dental caries, high</td>
</tr>
<tr>
<td>Q53.112</td>
<td>Unilateral inguinal testis</td>
<td>Z91.849</td>
<td>Unspecified risk for dental caries</td>
</tr>
<tr>
<td>Q53.13</td>
<td>Unilateral high scrotal testis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q53.211</td>
<td>Bilateral intraabdominal testes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q53.212</td>
<td>Bilateral inguinal testes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q53.23</td>
<td>Bilateral high scrotal testes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NEW CPT FOR 2017 AND EXPANDED PAYMENT COVERAGE - A WORTHY LOOKBACK

- Telemedicine - expanding coverage
- Care management – expanding coverage
- Non Face to Face Prolonged Services - expanding coverage
**TELEMEDICINE**

- Major changes have been made to the 2017 code manual
- **New Appendix (P)**
  - This appendix was developed to list all the codes that are applicable to the new telemedicine modifier
- **New symbol (a star ⭐)**
  - This symbol denotes codes that are listed in appendix P
- **New Modifier (95)**
  - The new modifier to denote when a service was provided via real-time interactive telecommunications system
Appendix P includes codes for services commonly performed by pediatric physicians, including:

- New and established patient office or other outpatient evaluation and management services (99201–99205, 99212–99215)
- New and subsequent hospital care (99231–99233)
- Inpatient and outpatient consultations (99241–99245, 99251–99255)
Appendix P – other CPT codes

- Prolonged services in the office or outpatient setting (99354, 99355)
- Individual behavior change interventions (99406–99409)
- Transitional care management services (99495, 99496)
- Remote real-time interactive video-conferenced critical care codes (0188T, 0189T)
TELEMEDICINE – MODIFIER 95

• Telemedicine Service Rendered Via a Real Time Interactive Audio and Video Telecommunications System.

• Modifier 95 may only be appended to the services listed in Appendix P. Appendix P is the list of CPT codes for services that are typically performed face-to-face but may be rendered via a real time (synchronous) interactive audio and video telecommunications system.
**Telemedicine — Modifier 95**

**Telemedicine Service Rendered Via a Real Time Interactive Audio and Video Telecommunications System:**

- Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional.
- The totality of the communication of information exchanged between the provider or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.
Telemedicine — Other Codes

- **HCPCS) code Q3014 - Originating Site**
  - the telehealth originating site facility fee (CPT 2017 does not include codes for reporting an originating facility fee)
  - report for hosting the patient during the telemedicine service (eg, providing conference or examination room, staff, etc to accommodate the telemedicine service).

- **HCPCS code T1014 – For internet line**
  - Physicians at an originating site may also be able to report the transmission service (eg, cost of telecommunications service) using (telehealth transmission, per minute, professional services bill separately), billing one unit for each minute of service.
CHRONIC CARE MANAGEMENT: REQUIRED ELEMENTS

CPT 99490

• At least 20 minutes of clinical staff time directed by a physician/QHP, per calendar month, with the following required elements:
  • At least 2 chronic conditions expected to last at least 12 months, or until the death of the patient
  • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  • Comprehensive care plan established, implemented, revised, or monitored
**Care Management Services**

- Chronic (99490) and Complex Chronic Care (99487, 99489)
- Provided by clinical staff under direction of physician or QHP
- Patient at home, rest home, or assisted living facility
- A plan of care must be documented and shared with the patient and/or caregiver.
- Reported only once per calendar month and only by the physician/QHP who assumes the care management role
- Do not count any clinical staff time on E/M visit day for time that would otherwise bundled into the E/M
COMPLEX CHRONIC CARE MANAGEMENT: REQUIRED ELEMENTS

CPT: 99487

- At least 2 chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Establish or substantial revision of comprehensive care plan (do not report CCCM if the care plan is unchanged or minimal change)
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

+99489: each additional 30 mi clinical staff time
TRANSITIONAL CARE MANAGEMENT

**99495:** requires the following:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge
- And per Medicare: certain non-F2F services as medically indicated

**99496:** requires the following:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge
- And per Medicare: certain non-F2F services as medically indicated
**Prolonged Service without Direct Patient Contact**

**99358:** Prolonged evaluation and management service before and/or after direct patient care; first hour

**+99359:** each additional 30 minutes (List separately in addition to code for prolonged service)

Service is NOT face-to-face time in the office or outpatient setting nor additional unit/floor time in the hospital

May be reported on a different date than the primary service to which it is related. However, it must relate to a service or patient where (face-to-face) patient care has occurred or will occur.

CMS - The projected payment rate for 99358 is $113.41 (facility and non-facility); for 99359, it is $54.38 (facility and non-facility)
Interprofessional Telephone/Internet Consultations

- 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/QHP or other qualified health care professional.

<table>
<thead>
<tr>
<th>CPT</th>
<th>Discussion/review time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99446</td>
<td>5-10 min</td>
</tr>
<tr>
<td>99447</td>
<td>11-20 min</td>
</tr>
<tr>
<td>99448</td>
<td>21-30 min</td>
</tr>
<tr>
<td>99449</td>
<td>≥ 31 min</td>
</tr>
</tbody>
</table>

The written or verbal request for telephone/Internet advice by the treating/requesting physician or other qualified health care professional should be documented in the patient’s medical record and written report provided to requesting physician.

- Medicare Fee Schedule 2016: “B” without published RVUs.
HOW TO IMPROVE CODING AND PAYMENT

Refresh business system with new code sets now, and have regular coding education

Review all Value based programs and learn the defined coding inputs so you capture clinical quality gap closures

Practice Population health, team based care, and improve the care model for your attributed or assigned populations
AAP Pediatric Coding Publications

AAP Pediatric Coding Newsletter™
Stay current with all the latest in pediatric coding and compliance.

Coding for Pediatrics, 2016
In its 21st edition, 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.

Pediatric ICD–10–CM: A Manual for Provider–Based Coding
In its first edition, this manual will assist pediatric providers, coders, and billing staff with a condensed version of the ICD–10–CM manual so that they can confidently manage the transition with accurate pediatric diagnostic coding.
AAP Coding Resources

• Coding At the AAP Site

  — One stop shop for all coding related resources from the AAP!

• AAP Coding Hotline
  aapcodinghotline@aap.org
CHANGE...IS CONSTANT IN HEALTH CARE

“It is not necessary to change... Survival is not mandatory”

- Edward Deming
  • Speaking to a group of Detroit automaker executives 1970s

(there will likely be no “Pediatric” bailout)
So...Thank You!!
**Schedule**

**Recommendations for Preventive Pediatric Health Care**

**Bright Futures/American Academy of Pediatrics**

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care, comprehensive health supervision and the need to avoid fragmentation of care.


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### EARLY CHILDHOOD

<table>
<thead>
<tr>
<th>AGE</th>
<th>Infancy</th>
<th>Toddler</th>
<th>Preschool</th>
<th>School Age</th>
<th>Teenage</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 mo</td>
<td>15 mo</td>
<td>18 mo</td>
<td>24 mo</td>
<td>30 mo</td>
<td>3 y</td>
</tr>
<tr>
<td><strong>HISTORY</strong></td>
<td><strong>MEASUREMENTS</strong></td>
<td><strong>SENSORY SCREENING</strong></td>
<td><strong>DEVELOPMENTAL/BEHAVIORAL ASSESSMENT</strong></td>
<td><strong>PHYSICAL EXAMINATION</strong></td>
<td><strong>PROCEDURES</strong></td>
</tr>
<tr>
<td>Birth</td>
<td>Length and Weight</td>
<td>Head Circumference</td>
<td>Language</td>
<td>Height, Weight, and Head Circumference</td>
<td>Newborn Blood Screening</td>
</tr>
<tr>
<td>1 mo</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newborn Blood Screening</td>
</tr>
<tr>
<td>6 mo</td>
<td></td>
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<td></td>
<td></td>
<td>Newborn Blood Screening</td>
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<tr>
<td>1 y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newborn Blood Screening</td>
</tr>
</tbody>
</table>

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**AN PRACTICE**

- Review in the ICD-10-CM system for the first time.
- Review in the ICD-10-CM system for the second time.
- Review in the ICD-10-CM system for the third time.
- Review in the ICD-10-CM system for the fourth time.
- Review in the ICD-10-CM system for the fifth time.
- Review in the ICD-10-CM system for the sixth time.
- Review in the ICD-10-CM system for the seventh time.
- Review in the ICD-10-CM system for the eighth time.
- Review in the ICD-10-CM system for the ninth time.
- Review in the ICD-10-CM system for the tenth time.
- Review in the ICD-10-CM system for the eleventh time.
- Review in the ICD-10-CM system for the twelfth time.
- Review in the ICD-10-CM system for the thirteenth time.
- Review in the ICD-10-CM system for the fourteenth time.
- Review in the ICD-10-CM system for the fifteenth time.
- Review in the ICD-10-CM system for the sixteenth time.
- Review in the ICD-10-CM system for the seventeenth time.
- Review in the ICD-10-CM system for the eighteenth time.
- Review in the ICD-10-CM system for the nineteenth time.
- Review in the ICD-10-CM system for the twentieth time.
- Review in the ICD-10-CM system for the twenty-first time.
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
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
Preventive Medicine Services

• Includes
  – Age appropriate anticipatory guidance/Risk factor reduction
  – Age appropriate counseling
  – Review of vaccine history
  – Ordering of appropriate labs and diagnostic procedures
  – Developmental surveillance
**Preventive Medicine Service**

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

• Is it time for NEW preventive medicine codes
  – Payment policies may deny other related services like EM done at same visit
  – It is administratively complex to bill
  – A growing pediatric morbidity
    ▪ BH conditions- ADHD, ODD, anxiety, depressions, ACES
    ▪ Obesity and Overweight
    ▪ Additional screening services per BF
    ▪ Acute or chronic illness evaluated at same visit as PM
    ▪ Genomic risk profiles drives individualized preventive care

• Is it time to reengineer the CPT codes for preventive care to better value complexity and bundles typical services ??
PM SERVICES AND ICD-10-CM

- **Z00.110**  Newborn under 8 days old
- **Z00.111**  Newborn 8 to 28 days old (NB weight check)
- **Z00.121**  Child health examination w/ abnormal findings (Use additional code to identify abnormal findings)
- **Z00.129**  Child health examination w/o abnormal findings
- **Z00.00**   Adult medical examination w/o abnormal findings
- **Z00.01**   Adult medical examination with abnormal findings (Use additional code to identify abnormal findings)
VACCINES AND ICD-10-CM REPORTING

• For every encounter, ICD-10-CM code **Z23** must be linked to both the product and vaccine administration CPT codes
VACCINES NOT GIVEN
ICD 10

• Z28.01 Due to of patient acute illness
• Z28.02 Due to chronic illness or condition
• Z28.03 Due to immune compromised state
• Z28.04 Due to allergy to vaccine or component
• Z28.09 Due to other contraindication
• Z28.1 Due to patient decision for reasons of belief or group pressure
VACCINES NOT GIVEN
ICD 10 cont’d

- Z28.20 Due to patient decision for unspecified reason
- Z28.21 Due to patient refusal
- Z28.29 Due to patient decision for other reason
- Z28.81 Due to patient having had the disease
- Z28.82 Due to caregiver refusal
- Z28.89 For other reason
- Z28.9 For unspecified reason
Like most veterinary students, Doreen breezes through chapter 9.
ICD-10-CM: New Codes for 2017

Worthy Lookback

- We have been on an ICD code freeze for the past 5 years
- Clinical need → code development
- The October 1, 2016 release is the culmination of 5 years worth of meetings/proposals
  - 1943 New codes
  - 422 Revised codes
  - 305 deleted*

*Codes are not “deleted” in ICD-10-CM, but these 305 codes no longer represent complete codes.
“DELETED” CODES

• Example: Idiopathic acute pancreatitis
• Prior to Oct 1, reported as:
  – K85.0 (Idiopathic acute pancreatitis)
• On Oct 1, 5th digit required. K85.0 will be denied as invalid code
• ICD-10-CM formatting:
  K85.0 Idiopathic acute pancreatitis
    K85.00 Idiopathic acute pancreatitis without necrosis or infection
    K85.01 Idiopathic acute pancreatitis with uninfected necrosis
    K85.02 Idiopathic acute pancreatitis with infected necrosis
New code added for Zika virus

- A92.5 Zika virus disease
  
  Zika virus fever, Zika virus infection, Zika NOS

- The AAP is developing new codes for perinatal exposure and perinatal infection as well as an “exposure” code outside of the perinatal period.

- Current, for exposure: **P00.2** (Newborn affected by maternal infectious and parasitic diseases)
New code added at **L03.21** Cellulitis and acute lymphangitis of face

**New Code:**

**L03.213** Periorbital cellulitis

– Includes preseptal cellulitis

The severity of this condition merited the inclusion of this code
CHAPTER 16 - CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD

• New Guideline at Categories P00-P04 Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery

• “These codes are for use when the listed maternal conditions (or birth process) are specified as the cause of confirmed morbidity or potential morbidity which have their origin in the perinatal period (before birth through the first 28 days after birth).”

• *Do not report these codes if the condition has been ruled out (Refer to Z05)*
**Z05** Encounter for observation and evaluation of newborn for suspected diseases and **conditions ruled out**

**Guideline:**

*This category is to be used for newborns, within the neonatal period (the first 28 days of life), who are suspected of having an abnormal condition unrelated to exposure from the mother or the birth process, but without signs or symptoms, and which, after examination and observation, is ruled out.*

**Excludes2**: newborn observation for suspected condition, related to exposure from the mother or birth process (**P00-P04**)

**Example**: observing for development of Neonatal Abstinence Syndrome; observing for development of sepsis.
Observation & Evaluation of Newborn

Z05.6 Observation and evaluation of NB for suspected genitourinary condition R/O

Z05.71 suspected skin/subcutaneous tissue R/O

Z05.72 suspected musculoskeletal condition R/O

Z05.73 suspected connective tissue condition R/O

Z05.8 other specified suspected condition R/O

Z05.9 unspecified suspected condition R/O
OBSERVATION & EVALUATION OF NEWBORN

Z05.0 Observation and evaluation of newborn for suspected cardiac condition ruled out
Z05.1 suspected infectious condition R/O
Z05.2 suspected neurological condition R/O
Z05.3 suspected respiratory condition R/O
Z05.41 suspected genetic condition R/O
Z05.42 suspected metabolic condition R/O
Z05.43 suspected immunologic condition R/O
Z05.5 suspected gastrointestinal condition R/O
CHAPTER 16 - CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD

• New codes were added at **P05.0 Newborn light for GA** and **P05.1 Newborn small for GA**

New Codes:

• **P05.09** Newborn light for gestational age, 2,500 grams and over (wt < 10%tile)

• **P05.19** Newborn small for gestational age, other (wt. and ht. <10%tile )
  (Newborn small for gestational age, 2500g and over)
CH 17 - CONGENITAL MALFORMATIONS, DEFORMATIONS AND CHROMOSOMAL ABNORMALITIES

Other new codes:

• **Q82.6** Congenital sacral dimple
  – Parasacral dimple

• **Q87.82** Arterial tortuosity syndrome

*Pediatrics in Review 2011;32;109*
**New Codes for Prophylactic Services:**

**Z29.11** Encounter for prophylactic immunotherapy for respiratory syncytial virus (RSV)

**Z29.12** Encounter for prophylactic antivenin

**Z29.13** Encounter for prophylactic Rho(D) immune globulin

**Z29.14** Encounter for prophylactic rabies immune globin

**Z29.3** Encounter for prophylactic fluoride administration

**Z51.6** Encounter for desensitization to allergens
New family history codes:

- **Z83.42** Family history of familial hypercholesterolemia
- **Z84.82** Family history of sudden infant death syndrome
Amblyopia, suspect

H53.041 - Amblyopia suspect, right eye

H53.042 - Amblyopia suspect, left eye

H53.043 - Amblyopia suspect, bilateral

These codes were created to be able to show that the physician is concerned that the child has significant factors for amblyopia and wants to ensure proper follow-up.
New Codes at **H90.A**
- **H90.A11** - Conductive hearing loss, **right ear**, with restricted hearing on the contralateral side
- **H90.A12** - **left ear**
- **H90.A21** - Sensorineural hearing loss, **right ear**, with restricted hearing on the contralateral side
- **H90.A22** - **left ear**
- **H90.A31** - Mixed conductive and sensorineural hearing loss, **right ear**, with restricted hearing on the contralateral side
- **H90.A32** - **left ear**
CHAPTER 9 – DISEASES OF THE CIRCULATORY SYSTEM

A new category was added

I16 Hypertensive crisis

New Codes:

I16.0 - Hypertensive urgency

I16.1 - Hypertensive emergency

I16.9 - Hypertensive crisis, UNSPEC
CHAPTER 11 – DISEASES OF THE DIGESTIVE SYSTEM

- At K02 Dental caries – a new includes note was added as follows

  **Includes:** caries of dentine
  early childhood caries
  pre-eruptive caries
  recurrent caries

Z29.3- prophylactic fluoride administration
CHAPTER 11 – DISEASES OF THE DIGESTIVE SYSTEM

• New codes were added under K52.2 Allergic and dietetic gastroenteritis and colitis

• K52.21 - Food protein-induced enterocolitis syndrome

• K52.22 - Food protein-induced enteropathy

• K52.29 - Other allergic and dietetic gastroenteritis and colitis
CHAPTER 11 – DISEASES OF THE DIGESTIVE SYSTEM

- New codes added at **K58** Irritable bowel syndrome

New Codes:
- **K58.1** Irritable bowel syndrome with constipation
- **K58.2** Mixed irritable bowel syndrome
- **K58.8** Other irritable bowel syndrome
CHAPTER 11 – DISEASES OF THE DIGESTIVE SYSTEM

• New codes added at K59.0 Constipation

New Codes:

• **K59.03** Drug induced constipation
  – Use Additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)

• **K59.04** Chronic idiopathic constipation
  – Includes functional constipation
CH 14 – DISEASES OF THE GENITOURINARY SYSTEM

- New subcategory and codes added at **N50.8 Other specified disorders of male genital organs**
- New Subcategory: **N50.81 Testicular pain**

**New Codes:**
- **N50.811** Right testicular pain
- **N50.812** Left testicular pain
- **N50.819** Testicular pain, unspecified
- **N50.82** Scrotal pain
- **N50.89** Other specified disorders of the male genital organs
CH 20 - EXTERNAL CAUSES OF MORBIDITY

- **W26.2** Contact with edge of stiff paper
  paper cut
- **W26.8** Contact with other sharp object(s), not elsewhere classified
- Contact with tin can lid
- **W26.9** Contact with unspecified sharp object(s)
CH 20 - EXTERNAL CAUSES OF MORBIDITY

• **X50.0** Overexertion from strenuous movement or load
  – Lifting heavy objects or weights
• **X50.1** Overexertion from prolonged static or awkward postures
  – Prolonged or static bending
  – Prolonged or static kneeling
  – Prolonged or static reaching
  – **Prolonged or static sitting**
  – Prolonged or static standing
  – Prolonged or static twisting
• **X50.3** Overexertion from repetitive movements
• **X50.9** Other and unspecified overexertion or strenuous movements or postures
EM- Office- 99201-99215
CMS Evaluation and Management Documentation Guidelines

• EM Documentation Guidelines
  – Centers for Medicare and Medicaid Services (CMS)
    » formerly Health Care Finance Administration (HCFA)
  – Have become the de facto industry standard
CMS and Clinical Presentation
Four Principles

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.

It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. *(EM Upcoding- MDM explains best the work needed)*

The volume of documentation should not be the primary influence upon which a specific level of service is billed. *(targets extraneous EMR driven History and Examination)*

Documentation should support the level of service reported.

*Medicare Claims Processing Manual 30.6.1(A)*
INTERPROFESSIONAL

TELEPHONE/INTERNET CONSULTATIONS

• Review of pertinent medical records such as laboratory studies, imaging studies, medication profile, pathology specimens, and other patient data is included in the telephone/Internet consultation service and is not be reported separately. This review should be performed immediately before or after the telephone/Internet consultation.

• The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal/Internet discussion.

• This service should not be reported more than once within a seven-day interval.

• If more than one telephone/Internet contact(s) is required to complete the consultation request, the entirety of the service and the cumulative discussion and information review time should be reported with a single code.
INTERPROFESSIONAL
TELEPHONE/INTERNET CONSULTATIONS

• Not reportable if consultant has had F2F encounter in past 14 days
• Not reportable by a consultant who has agreed to accept transfer of care before the telephone/Internet assessment, but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial interprofessional telephone/Internet consultation
• Not reportable when the telephone/Internet consultation leads to an immediate transfer of care or other face-to-face service within the next 14 days or next available appointment date of the consultant, these codes are not reported