A Doctor and a Coder Walk Into a Bar…

PCC Users' Conference 2023

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UC 2023

PCC
Pediatric EHR Solutions

Disclaimer

The information presented is shared for the sole purpose of examining medical Billing and Practice Management approaches and issues. Though every effort has been made to develop accurate materials, this guidance is informal and is not intended to be legal advice. Decisions relating to the management of your practice, coding your work, setting your fees, etc., should be made independently.

E/M Leveling: TIME

Midnight to midnight on DOS

New Patients		Established Patients	
15-29 minutes	**99202**	10-19 minutes	**99212**
30-44 minutes	**99203**	20-29 minutes	**99213**
45-59 minutes	**99204**	30-39 minutes	**99214**
60-74 minutes	**99205**	40-54 minutes	**99215**

***99211** N/A

E/M Leveling: TIME Activities

Activities - LONG list on page 12 CPT 2023 includes:

Clinician's own time spent in

- Visit prep, history, exam **and/or** evaluation
- Counsel & Educating the patient/**family/caregiver**
- Order meds, tests, procedures
- Refer & Communicate w/other HCPs (*when not separately reported*)
- Document clinical info in EHR or other health record
- Independently interpret results (*not separately reported*) and communicate results to patient/**family/caregiver**
- Care coordination (*not separately reported*)

American Medical Association. CPT Professional 2023 and E/M Companion 2023 Bundle (p. 12). American Medical Association. Kindle Edition.

E/M Leveling: TIME Updates in 2023

Effective 1/1/23

- 2021 E&M leveling changes (basing them on MDM or time) got pulled through to many other places of service and times defined for all
  - Observation, Domiciliary/Rest Home/Custodial Care procedures deleted/merged into other places of service
- Leveling based on Time requires face-to-face encounter
- Time no longer includes:
  - Travel
  - General teaching / discussion not required to manage a specific patient

E/M Leveling: MDM

Number & Complexity of Problems Addressed

Amount and/or Complexity of Data

Risk of morbidity from *additional diagnostic testing or treatment*

2023 E&M Coding Tool

Adapted from: Table 2 –CPT E/M Office RevisionsLevel of Medical Decision Making (MDM)
https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

TODAY'S PROBLEM LEVEL	TODAY'S DATA LEVEL	TODAY'S RISK LEVEL	TODAY'S VISIT
(Circle one) LEVEL: 2 3 4 5	*(Circle one)* LEVEL: 2 3 4 5	*(Circle one)* LEVEL: 2 3 4 5	*(Circle one)* LEVEL: 2 3 4 5 Final Level assigned, based on MDM or Total Time
Number & Complexity of problems addressed	**Amount and/or Complexity of Data** Each unique test, order, or document contributes to a combination of 2 or of 3 in Category 1 below.	**Risk** of morbidity from additional diagnostic testing or treatment	
LEVEL 2 1 self-limited or minor problem	**LEVEL 2** Minimal or none	**LEVEL 2** Minimal risk	**TOTAL TIME ON DOS: _____**
LEVEL 3 ■ 2 or more self-limited or minor problems; **or** ■ 1 stable chronic illness; **or** ■ 1 acute, uncomplicated illness or injury; **or** ■ 1 stable, acute illness; **or** ■ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**LEVEL 3** *One category required* **CATEGORY 1:** *Any 2 from the following:* ■ Review of **prior external note(s) from each unique source**; ■ Ordering of **each unique test or** ■ Review of the **result(s) of each unique test;** **CATEGORY 2:** ■ Assessment requiring an independent historian(s) *For independent interpretation and discussion of management or test interpretation, see Level 4 or 5.*	**LEVEL 3** Low risk	**LEVEL 2** 15–29 mins NEW: 99202 10–19 mins EST: 99212 **LEVEL 3** 30–44 mins NEW: 99203 20–29 mins EST: 99213
LEVEL 4 ■ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** ■ 2 or more stable chronic illnesses; **or** ■ 1 undiagnosed new problem with uncertain prognosis; **or** ■ 1 acute illness with systemic symptoms; **or** ■ 1 acute complicated injury	**LEVEL 4** *One category required* **CATEGORY 1:** *Any 3 from the following:* ■ Review of **prior external note(s) from each unique source**; ■ Ordering of **each unique test or** ■ Review of the **result(s) of each unique test**; ■ Assessment requiring an independent historian(s) **or** **CATEGORY 2:** ■ Independent interpretation of test performed by another MD/QHCP/appropriate source (not separately reported); **or** **CATEGORY 3:** ■ Discussion of management or test interpretation with external MD/QHCP/appropriate source (not separately reported)	**LEVEL 4** Moderate Risk **EXAMPLES ONLY:** ■ Prescription drug management ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery without identified patient or procedure risk factors ■ Diagnosis or treatment significantly limited by social determinants of health	**LEVEL 4** 45–59 mins NEW: 99204 30–39 mins EST: 99214 **LEVEL 5** 60–74 mins NEW: 99205 40–54 mins EST: 99215
LEVEL 5 ■ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** ■ 1 acute or chronic illness or injury that poses a threat to life or bodily function	**LEVEL 5** *Two categories required* **CATEGORY 1:** *Any 3 from the following:* ■ Review of **prior external note(s) from each unique source;** ■ Ordering of **each unique test** or ■ Review of the **result(s) of each unique test**; ■ Assessment requiring an independent historian(s) **or** **CATEGORY 2:** ■ Independent interpretation of test performed by another MD/QHCP (not separately reported); **or** **CATEGORY 3:** ■ Discussion of management or test interp with external MD/QHCP/appropriate source (not separately reported)	**LEVEL 5** High Risk **EXAMPLES ONLY:** ■ Drug therapy requiring intensive monitoring for toxicity ■ Decision regarding elective major surgery with identified patient or procedure risk factors ■ Decision regarding emergency major surgery ■ Decision regarding hospitalization or escalation of hospital-level care ■ Decision not to resuscitate or to de-escalate care due to poor prognosis ■ Parenteral controlled substances	PCC Pediatric EHR Solutions

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Overview

- Most of the coding lectures that I have encountered to date are either geared to coders or to adult medicine
- My goal for today is to help the pediatric provider clarify some coding nuances
- BCD does regular self coding audits. The purpose of these audits is not only to make sure we are all coding appropriately, but also to discuss and clarify some of the less straightforward coding visits. Most of the vignettes I will present are cases discussed by our coding team and managing partners.
- I have chosen 7 clinical cases to help illustrate some common mistakes as well as highlight some areas where you may be able to improve coding, and therefore reimbursement.

Vignette #1:

A 4 mo old ex 25 week male presents for synagis injection. Patient with significant PMHx of a 3 month NICU hospitalization for prematurity with severe BPD and pulmonary hypertension. Patient is doing remarkably well now and Mom would like his breathing checked for reassurance, but there are no new concerns. He is on no medication. He is feeding well and has had appropriate interval weight gain.

The physical exam is normal.

Diagnoses:

1. Ex 25 week premature infant
2. Chronic BPD
3. Pulmonary hypertension

Plan: Synagis shot given.

Vignette#1: Coding

Coding: 99214

Problem Level 4: 2 stable chronic illnesses: (BPD and pulmonary hypertension)

Data Level 3: independent historian

Risk Level 4: prescription drug management (injection of a medication)

Vignette #2:

18 yo male presents to the office alone for evaluation of 5 days of cough and congestion. No reported fever, good appetite, energy is adequate but he is waking frequently at night due to the cough.

Physical exam is overall normal, nasal passages are swollen, and there are some coarse BS on lung exam.

Diagnosis:

1. Viral Bronchitis

Plan: Patient will f/u next week if symptoms persist and was told to take Benadryl at night to help with the post nasal drip and hopefully improve sleep.

Vignette #2 Coding:

Coding: 99213

Problem Level 3: 1 acute uncomplicated illness (viral bronchitis)

Data Level 2: Minimal or none

Risk Level 3: OTC medication recommended (Benadryl)

Vignette #3:

4 m.o. breastfed female w/no PMHx presents w/full body rash. Mom states baby has never had a rash like this before. Rash is worse on face and extremities. Baby is miserable, constantly rubbing head and body, not sleeping well, and just fussy. Worth mentioning the physician just opened a new office, and patient followed doctor to new location and this is baby's first visit.

Physical exam is significant for full body eczematous patches with areas of excoriation and bleeding.

Diagnosis: eczema.

Plan: Discuss possibility of dairy intolerance and removing dairy from Mom's diet. Review skin products to use and avoid, reinforce importance of skin hydration, discuss bleach baths, and prescribe triamcinolone ointment.

Vignette #3 Coding:

Coding: 99214

Problem Level 4: chronic illness with exacerbation (eczema)

Data Level 3: independent historian (mom)

Risk Level 4: prescription medication (triamcinalone 0.1%)

Vignette #4:

A 15 month old male presents w/cough, reported SOB. Afebrile, coughing, fussy and seems minimally SOB. Parents gave albuterol overnight that helped. This AM continues w/some increased WOB. Parents state has been doing great, has not needed albuterol for last 9 mos, until last night. This AM ate ok, but less than usual. Continues to drink well. PMHx is significant for ICU admission for RSV bronchiolitis at 5 mos old & spent 4 days in PICU and 1 day on floor. After discharge, prolonged (3-4 week) recovery period, but since then has not had any recurrent wheeze.

Physical exam: afebrile, O2 sat 97% RA, TMs nl, nasal congestion, lungsw/diffuse wheezing w/poor air entry at bases, mild retractions, tachypnea (RR 44). RSV was negative. Albuterol neb tx given w/some improvement followed by Duoneb tx. Patient improved dramatically w/resolution of tachypnea.

Vignette #4 (cont'd)

Diagnosis: RAD, tachypnea

Plan: Q4 hr albuterol nebs, will f/u in the office tomorrow to recheck lungs, but tachypnea improved dramatically with in office albuterol and duoneb (RR 44 initially to RR 27 after treatments)

Vignette #4 Coding:

Coding: 99213 vs 99214 ??

Problem Level ?: level 3 acute uncomplicated illness vs level 4 chronic problem with exacerbation (RAD #1 or #2 since wheezed with RSV?)

Data Level 3: independent historian (parents). Note, only 1 test done so does not meet criteria for level 4

Risk Level 4: prescription drug management. Albuterol and Duoneb were given in the office and will continue albuterol at home every 4 hrs

Vignette #5:

14 yo female presents with mom who states has had 2 day h/o sore throat, nausea, abdom discomfort, minimal congestion, HA, malaise, fever. Was just at friend's house who was diagnosed w/strep throat.

Physical exam: erythematous tonsils, palatal petechiae, and shotty LAD. Remainder of PE wnl. Labs: Strep NAT was +, U/A was negative.

Diagnosis: Strep Throat

Plan: Amoxicillin 875 mg BID for 10 days

Vignette #5 Coding:

Coding: 99214

Problem Level 3: acute uncomplicated illness

Data Level 4: Strep NAT test, U/A, and independent historian

Risk Level 4: Amoxicillin prescribed

Vignette #5 Rationale:

1. I have commonly seen practitioners code this a level 4 for Problem with the justification that this is an acute illness with systemic symptoms (HA and nausea). Unfortunately, that is not the case. Here is the AAP coding hotline response:

The AMA defines acute illness with systemic symptoms as "An illness causing systemic symptoms and with high risk of morbidity without treatment."
— For systemic general symptoms (eg, fever, body aches, fatigue) in a minor illness that may be treated to alleviate symptoms, see self-limited or minor or acute, uncomplicated illness.
— Systemic symptoms may not be general but may be single system (eg, juvenile oligoarticular arthritis with only musculoskeletal symptoms).
— Examples may include pyelonephritis or bacterial gastroenteritis.

Vignette #5 Rationale: (cont'd)

2. While I think it is appropriate to do a urinalysis with abdominal pain in a 14 yo female w/nausea and abdominal discomfort, we have to be careful to not do the test just to get to a level 4 visit, but rather because it is medically indicated. I personally would not have initially done a u/a here. Sure, if the strep test was negative, or if the parent was concerned about UTI; both good reasons to do a urinalysis.

Remember, do a test because you think it is medically indicated, not because you want to get to a level 4 visit.

Vignette #6:

Baby B was born by C/S due to NRFHR at 29 6/7 wks. BW was 1080 gm. The twins were monochorionic diamniotic twins (ie shared placenta but have their own sacs). IVF pregnancy and Mom with a h/o obesity, and hypothyroidism during pregnancy and was on synthroid throughout pregnancy. Baby B was diagnosed with TAPS (Twin Anemia Polycythemia Sequence) Stage II at 26 weeks. Baby A donor and Baby B recipient.

Physical exam: premie facies, nl newborn exam

Vignette #6 (cont'd): Diagnoses

1. Bilateral ROP and will follow up with ophthalmology at 2 weeks.
2. Needs Hb electrophoresis at 120 days after last transfusion as NB screen prior to transfusion was indeterminate.
3. Apnea of Prematurity. 1 episode of apnea, treated x1 with caffeine. No subsequent episodes. Diagnosed with BPD, required BCPAP then intubated. Gradually weaned to RA after course of Lasix and discharged Diuril and Spironolactone.
4. Echo showed PFO and mild intraventricular wall flattening. Will f/u with cardiology in a month.
5. Patient was slow to feed so started on Enfamil AR 22. Improved rate of weight gain (discharge weight).
6. Had a bout of MSSA bacteremia, had PICC line and was successfully treated w/Oxacillin and Gentamycin.
7. Pulmonary hypertension diagnosed by echo and has pulmonary f/u in 4-8 weeks.
8. Anemia– per hematology, we will recheck HB in 2 weeks.
9. Breech presentation– will need hip u/s done in 2 weeks.

Vignette #6 coding

Coding: 99214

Problem Level 4: 2 or more stable chronic illnesses (ROP, pulmonary hypertension, etc)

Data Level 5: case discussed with NICU attending, multiple records and test results reviewed

Risk Level 3: minimal (as pt not at high risk at the time of the visit)

An even better option: Bill the visit as Transition of Care 99495, 99496 (note: typically these visits are reimburse 2-3x a 99215)

Vignette #6 TCM - Protocol Elements

Transition of Care, Initial Contact

Informant/Relationship

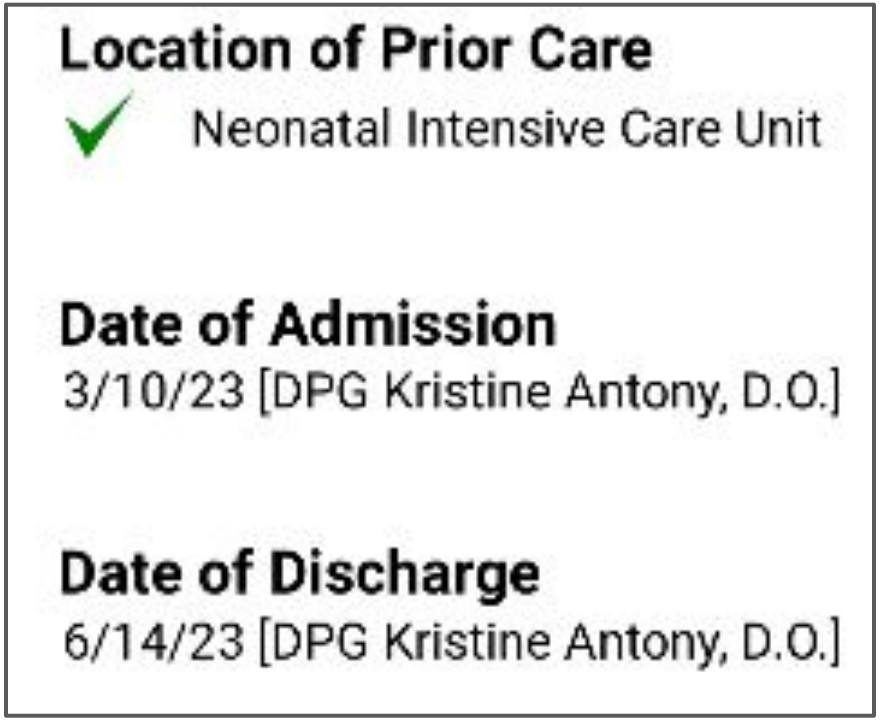
- ✓ Mother
- ✓ Father
- ✓ Other

  NICU notes [DPG Kristine Antony, D.O.]

Transition of Care (ARRA)

- ✓ Patient transitioned to my care from another clinical setting [DPG Kristine Antony, D.O.]
- ✓ Medication Reconciliation performed [DPG Kristine Antony, D.O.]

Vignette #6 TCM - Protocol Elements (cont'd)



Vignette #6 TCM - Protocol Elements (cont'd)

Procedures Performed

PICC line insertion [DPG Kristine Antony, D.O.]
Umbilical venous catheter placed [DPG Kristine Antony, D.O.]
endotracheal tube placement [DPG Kristine Antony, D.O.]

Medication

Diuril, ferrous sulfate, PVS, Spirinolactone, Gentimycin, Oxacillin, Lasix, nasal dexamethasone, Caffeine

Vignette #6 TCM - Protocol Elements (cont'd)

Summary

Patient was born via C/S due to NRFHR at 29 6/7 days. IVF Mon-Di twin gestation, breech, PNLs negative. Mom with history of obesity and had hypothyroidism during pregnancy and was on Synthroid during pregnancy. Diagnosed with Twin Anemia Polycythemia Sequence Stage II at 26 weeks. infant A donor and Infant B recipient. At CHOP, failed attempt of cauterization due to poor visualization during fetoscopy on 2/20/23 in utero. Fetal ECHO showed cardiomegaly and trivial pericardial effusion and aneurysmal appearing PFO, s/p betamethasone and rescue and amnioinfusion. Diagnosed with bilateral ROP, followed by Optho and needs outpatient follow up in 2 weeks. Had "indeterminate" result for Hemoglobinopathy with last NBS so needs Hb electrophoresis at 120 days after last transfusion. Received blood transfusions during hospitalization with normalization of H/H. Hematology consulted and recommended outpatient monitoring of H/H with follow up only needed if H/H not stable. Needs to continue Fe supplementation with PVS. ECHO showed small PFO, needs cardiac follow up in 5 months. Received Cafcit (caffeine) for apnea episodes. Had one episode 5 days ago which led to an additional 5 days of monitoring in the NICU and has been fine since. HUS showed mild asymmetric distention of left lateral ventricle, repeat was stable. Diagnosed with BPD, required BCPAP then intubated then gradually weaned to RA after course of lasix and start of Aldactone and Diuril. Required nasal dexamethasone drops for nasal granuloma (improved). ECHO also showed mild interventricular septal flattening which led to pulmonary HTN (off diuretics so then they were started back and patient was discharged on them). Has follow up with Pulm in 3-4 weeks. Had slow feeding on EBM so switched to Enfamil AR 22 calorie and doing better. Had a bout of constipation so started on Prune Juice which helped. Had MSSA Bacteremia, treated with Oxacillin and Gentamycin, ID consulted. PICC line placed and received 10 days of antibiotics. Abd US, Xray of forearm were normal. Required photo until bili normalized. Thrombocytosis resolved on it's own. Needs follow up with NICU follow up clinic in 4 months and Feeding specialist/PT in 1 month.

Vignette #6 TCM - Protocol Elements (cont'd)

Encounters

Yes No N/A

- Within 2 business days (required)
- Within 7 days of discharge (highly complex)

Billing

Medical Procedure

Transitional Care Management, Highly Complex (Ordered)

1 Task (0 Completed)
Task: Complete Task
To: ant
Due: 06/15/23

Vignette #7

16 yo male presents w/mom who states he woke 3 days ago with “weird” sensation in hands. He was not good at describing symptoms and Mom ignored him. But, yesterday, at BBall game was struggling to even dribble ball, was taken out of game for poor performance while is usually star athlete. Today, states hands feel “weird”, touch sensation is “off”, palms tingling and feel numb. Sensations extend to fingers but not as severe as palms. Both hands feel equally affected. Also mentioned that his tongue feels numb, but that taste is intact.

PE: nl fundoscopic exam, CN grossly intact, b/l hand and arm strength 5/5, but pt reports feeling weaker grip than usual. Nl pinprick test b/l. Tongue w/FROM and nl appearance and reporting nl taste.

Vignette #7 (cont'd)

DX:

1. Numbness of hands
2. Tongue symptoms

DDX: MS, brain tumor, psychogenic, other

Discussed case with the pediatric neurologist, he agreed to see the patient the next day and he would order any necessary labs

Vignette #7 Coding:

Coding: 99214

Problem Level 4: diagnosis of a new problem of uncertain prognosis (numbness, tongue symptoms)

Data Level 4: discussion of management with an external MD (neurologist)

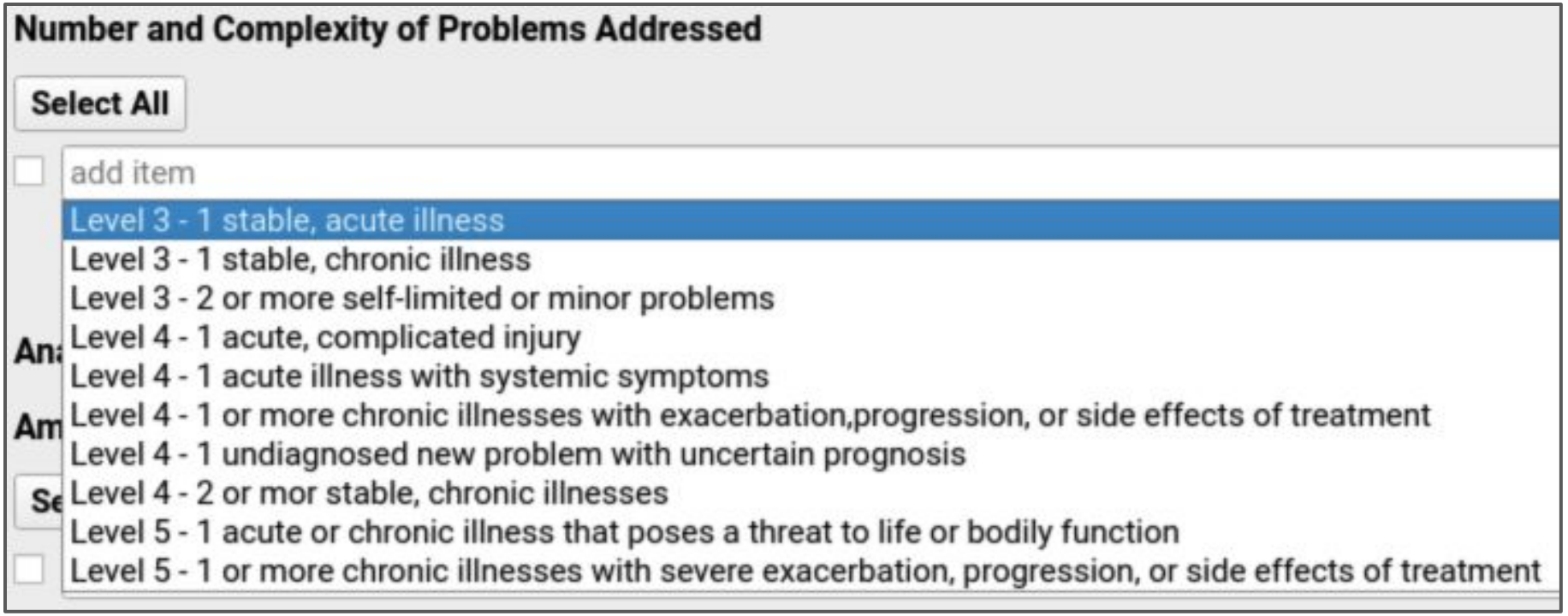
Risk Level 2: minimal (No additional diagnostics or treatment ordered)

BCD Health Partners' Approach to Coding Documentation

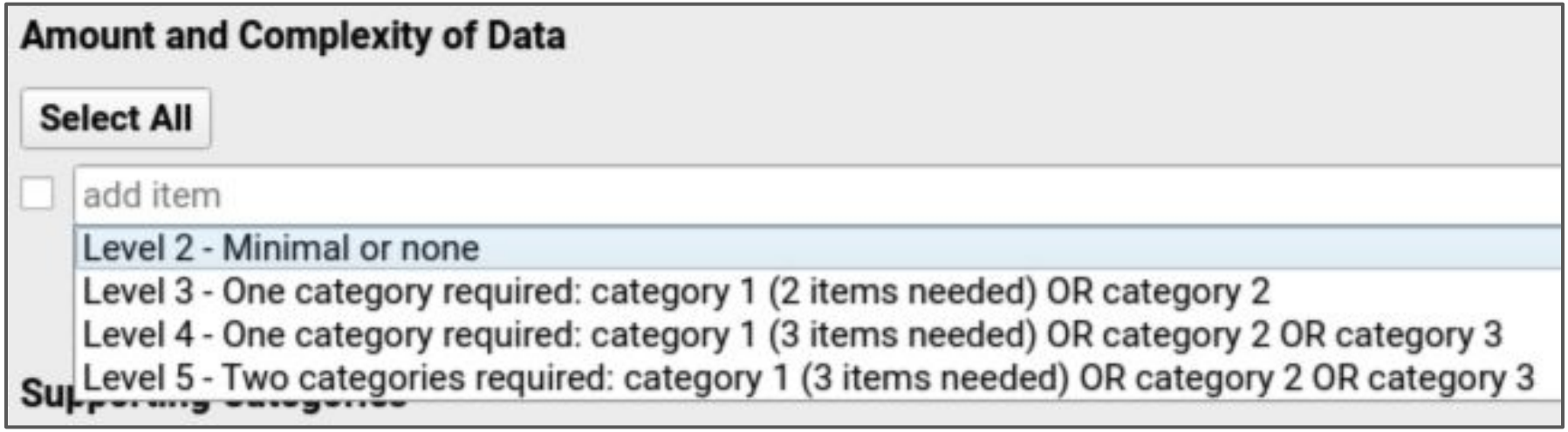
We document MDM at the bottom of each visit to ensure:

1. Provider understands and documents justification for their coding level
2. Allows for self-auditing, and help BCD with internal auditing to ensure the providers understand proper coding
3. Billers can easily depute denials or rejected claims (they literally cut and paste our MDM section into claim disputes)

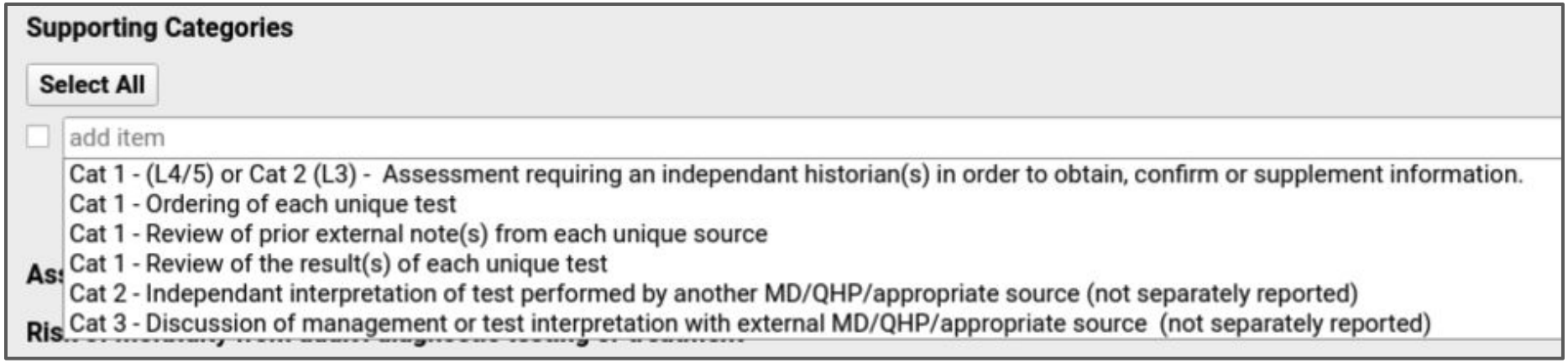
BCD Health Partners' Approach - Problems



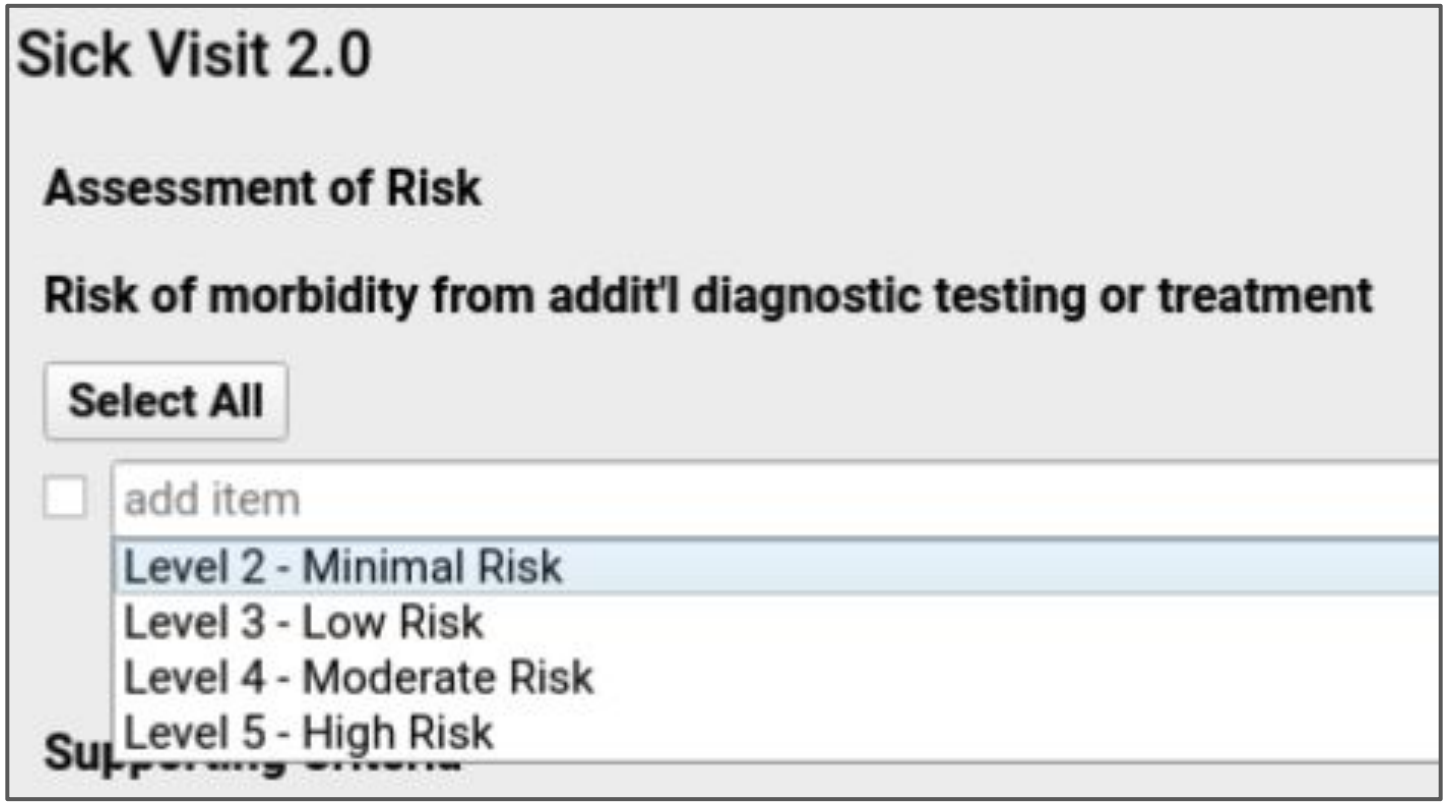
BCD Health Partners' Approach - Data



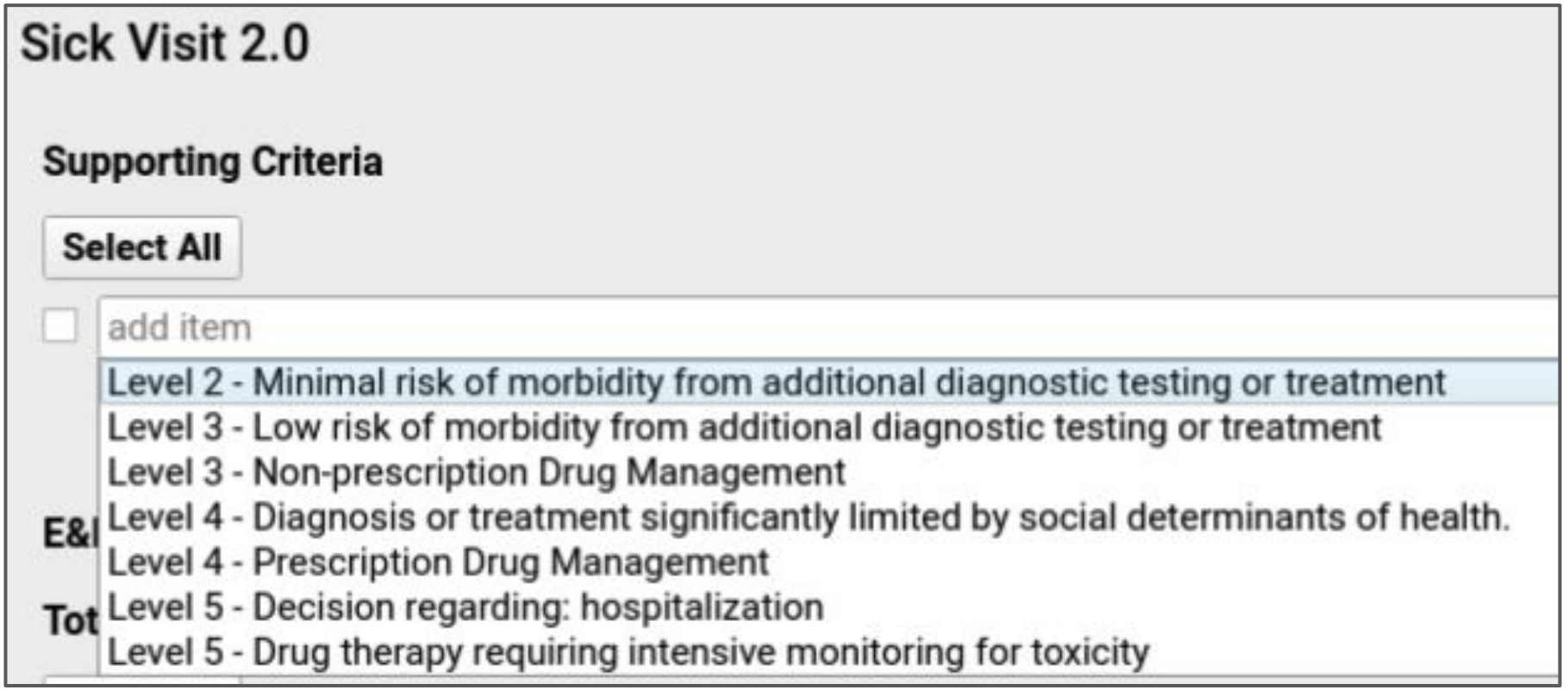
BCD Health Partners' Approach - Data Categories



BCD Health Partners' Approach - Risk



BCD Health Partners' Approach - Risk Examples



Documentation Goals

A lot less is required for documentation to support E&M coding now. Remember, though, you still need to write a thorough history and physical that accurately and completely captures the visit. Proper documentation is a component of good medical care. Lastly, always protect yourself and make sure your documentation would stand up in court.

What Questions Do You Have?