A Doctor and a Coder Walk Into a Phone Booth…

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UC 2024

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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.

Session Goals

1. Understand E&M leveling requirements
2. Apply leveling concepts to clinical vignettes
3. Improve confidence in your leveling

2024 CPT Updates - Appendix Q: COVID Vaccines

These CPTs marked as NEW in 2024 manual are included in AMA's online PDF version (https://bit.ly/2024COVIDVax)

- 91312 SARS-Cov-2 mRNA-LNP 12 yrs and older Pfizer
- 91315 SARS-Cov-2 mRNA-LNP 5-11 yrs Pfizer
- 91317 SARS-Cov-2 mRNA-LNP 6m-4 yrs Pfizer
- 91313 SARS-Cov-2 mRNA-LNP 12 yrs and older Moderna
- 91314 SARS-Cov-2 mRNA-LNP 6m-11 yrs Moderna
- 91316 SARS-Cov-2 mRNA-LNP 6m-5 yrs Moderna

2024 CPT Updates - NEW Add-on code: Pelvic Exam

+99459 Pelvic examination

List separately in addition to code for primary procedure; Bill with:

Consults	9924_
Sick Visits	9920_, 9921_
Preventive Care	9938_, 9939_

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2024 CPT Updates - +G2211 - Current Wisdom

"Visit complexity inherent to E/M associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition (add-on code, list separately in addition to office/outpatient E/M visit, new or established)"

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2024 CPT Updates - Bits and Bobs

Code Use: Golden Rule Reinforced - Choose the CPT that accurately identifies the service performed

Time: Many codes other than E&M are selected based on time.

- Midpoint applies to some (NOT E&M)
- Be clear about units considerations apply (days for some services, hour by hour for others (IV hydration, eg)
- DO NOT include time spent in these other timed services in E&M

2024 CPT Updates - E&M: A/V & Audio-Only Criteria

Services listed in Appendices P and T must satisfy the following criteria:

...totality and quality of the communication of info exchanged between Physician/QHP and the patient during synchronous telemedicine must be of an amount and nature that would be sufficient to meet requirements for the same service if they were to be rendered in-person face-to-face

AND ...

2024 CPT Updates - E&M: A/V & Audio-Only Criteria

…evidence supports the benefits of performing service through telecommunications. Include but not limited to these examples:

- Facilitates diagnosis or treatment plan that may reduce complications
- Reduces recovery time
- Enhances access to care (rural, vulnerable pts)
- Increases rapidity of resolution

Decreases Diagnostic or therapeutic interventions

- Hospitalizations
- In-person visits to ED, Physician/QHP (incl UC)
- Quantifiable symptoms

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2024 CPT Updates - Risk

In E&M leveling context, Risk level is determined by the clinician's assessment of Risk of complications and/or morbidity or mortality of *patient management*

Risk to the patient *from their condition*, however, is a factor in the Number and Complexity of Problems (Uncertain prognosis, threat to life or bodily function, eg)

2024 CPT Updates - Split or Shared Visits

When Physicians / QHPs act as part of a team, Physician / QHP may report service if:

- Physician / QHP's time was the majority spent on the day
- Physician / QHP:
  - made or approved management plan and takes responsibility for that plan with its inherent risks of complications and/or morbidity or mortality of patient management
  - does not have to personally assess independent historian or order/review tests
  - does have to personally interpret tests and discuss management plan or test interpretation

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Incident To ***Billing***…

Tension between Non-MDs working at the top of their license and fair payment. CMS requirements for Incident To billing include:

- Are an integral part of pt's treatment when the physician … personally performed initial service and remains actively involved in the course of treatment.
- Physician or other listed practitioner provides direct supervision for the "incident to" services, and only the physician or other listed practitioner who supervises the incident to services may bill them.

E/M Leveling: TIME Activities

LONG list on page 14 CPT 2024 includesClinician's *own* time spent in:

- prepare to see the pt (eg, review of tests)
- obtain **and/or** review separately obtained history
- perform a medically appropriate examination **and/or** evaluation
- counsel and educate the pt/family/caregiver
- order medications, tests, or procedures
- refer and communicate with other HCPs *(when not separately reported)*
- document clinical information in the health record
- independently interpret *(not separately reported)* and communicate results to the pt/family/caregiver
- care coordination (not separately reported). Visit prep, history, exam **and/or** evaluation

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E/M Leveling: TIME in 2024

Midnight to midnight on DOS
Minutes must now be met or exceeded

New Patients		Established Patients	
99202	15 mins	**99212**	10 mins
99203	30 mins	**99213**	20 mins
99204	45 mins	**99214**	30 mins
99205	60 mins	**99215**	40 mins

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E/M Leveling: MDM

Number & Complexity of Problems Addressed	Amount and/or Complexity of Data	Risk of morbidity from *additional diagnostic testing or treatment*

http://bit.ly/PCC2024EnMTool

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2024 E&M Coding Tool

Adapted from: Table 1: Levels of Medical Decision Making (MDM)

TODAY'S PROBLEM LEVEL	TODAY'S DATA LEVEL	TODAY'S RISK LEVEL	TODAY'S VISIT
(Circle one)	*(Circle one)*	*(Circle one)*	*(Circle one)*
LEVEL: 2 3 4 5	LEVEL: 2 3 4 5	LEVEL: 2 3 4 5	LEVEL: 2 3 4 5

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	Final Level assigned, based on MDM or Total Time
LEVEL 2 1 self-limited or minor problem	**LEVEL 2** Minimal or none	**LEVEL 2** Minimal risk	**TOTAL TIME ON DOS MUST MEET OR EXCEED:**
LEVEL 3 ■ 2 or more self-limited or minor problems; **or** ■ 1 stable chronic illness; **or** ■ 1 acute, uncomplicated illness or injury ■ 1 stable, acute illness ■ 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	**ESTABLISHED PATIENTS** 10 mins 99212 20 mins 99213 30 mins 99214 40 mins 99215
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	**NEW PATIENTS** 15 mins 99202 30 mins 99203 45 mins 99204 60 mins 99205
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 ■ Decision regarding parenteral controlled substances	

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Overview

Why am I doing a coding talk?

A special thank you to Stefanie Muntean-Turner CPC, CPMA. Stefanie is the Health Policy and Coding Specialist at the AAP who answers all the AAP Coding Hotline questions. She graciously answered numerous of my questions in preparation for today's talk.

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. I am bringing the pearls that I have learned from my unique position of overseeing our coding committee and all of the billing issues that arise at BCD.

I have chosen 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 6 mo old ex 34 week premature male presents to our office for his first visit. The parents have brought him to the office because they would like to discuss nirsevimab. Patient's past medical history is significant for poor weight gain and chronic severe reflux. His weight has improved and he is now on the chart, and while the reflux continues to be problematic he is gaining adequate weight with thickened feeds and no medication. He currently weighs 6.8kg (7th percentile). The physical exam is essentially normal, with minimal tenderness of his abdomen, consistent with reflux.

Diagnosis: 34 week premie, chronic reflux (stable)

Plan: After a discussion of the pros and cons the parents decide to give nirsevimab. 1 mg of nirsevimab was administered.

Vignette#1: Coding

Problem Level 4: 1 stable chronic illness (reflux)
Data Level 3: parents are independent historian
Risk Level 3: low risk (if medication had been discussed for reflux management, even if not given, could be moderate risk)

Coding: 99203-25, 90381 (RSV monoclonal antibody), 96380 (admin code)

Documentation note:

In order to bill the counseling code 96380, you MUST document the all vaccine components discussed and state date and QHP who did the counseling. In our office we have the following statements with check boxes:

I. I personally provided parent education about immunizations. The appropriate CDC VIS was provided for each vaccine. Parent was counseled about the risks and benefits of each vaccine antigen administered. Verbal consent was obtained for each of the vaccines given.
II. Vaccine counseling done by MD/PNP

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 breath sounds on lung exam.

Diagnosis: 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

Problem Level 3: 1 acute uncomplicated illness (viral bronchitis)
Data Level 2: Minimal or none
Risk Level 3: OTC medication recommended (Benadryl)

Coding: 99213, G2211

Vignette #3:

4 month old breastfed female with no PMHx presents with 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 her head and body, not sleeping well, and just fussy. Worth mentioning that this physician just opened a new office, and the patient followed the doctor to this new location and this is baby's first visit at this office.

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

Vignette #3: (continued)

Diagnosis: eczema

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

Vignette #3: Coding

Problem Level 4: chronic illness with exacerbation (eczema)
Data Level 3: independent historian (mom)
Risk Level 4: prescription drug management (triamcinalone 0.1% prescribed)

Coding: 99214, G2211

Vignette #4:

A 15 month old male presents with cough and reported shortness of breath. He started with congestion about 3 days ago but his symptoms have worsened over the last 24 hrs. The patient is afebrile but fussy. Parents gave albuterol overnight that helped. Today he continues with some increased work of breathing. Parents state he has been doing great and has not needed albuterol for last 9 months, until last night. This AM he ate ok, but less than usual, and he 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) respiratory recovery period requiring albuterol, but since then has not had any recurrent wheeze.

Vignette#4: (continued)

Physical exam: afebrile, O2 sat 97% RA, TMs normal, nasal congestion, lungs with diffuse wheezing and poor air entry at bases, mild retractions, tachypnea (RR 44). RSV was negative.

Albuterol nebulizer treatment was given with minimal improvement. A Duoneb treatment was then given and at this point the patient improved dramatically with resolution of his tachypnea.

Vignette #4: (continued)

Diagnosis: RAD, viral syndrome

Plan: Continue Q4 hr albuterol nebs at home, he will follow up in the office tomorrow to recheck lungs and respiratory rate (note: tachypnea improved dramatically with RR 44 initially to RR 27 after treatments).

Vignette #4: Coding

Problem Level 4: Chronic illness with exacerbation (RAD with wheezing)
Data Level 3: Independent historian (parents). 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

Coding: 99214, G2211

Vignette #5:

14 yo female presents with mom who states she has had a 2 day history of sore throat, nausea, abdominal discomfort, minimal congestion, headache, malaise, and fever. She was just at a friend's house who was diagnosed with strep throat. In addition, the patient had a UTI last month and mom would like to test her urine. Her physical exam was significant for erythematous tonsils, palatal petechiae, and shotty LAD. Remainder of the physical exam is within normal limits.
Labs: Strep NAT was positive, U/A was negative.

Diagnosis: Strep Throat

Plan: Amoxicillin 875 mg BID for 10 days

Vignette #5: Coding

Problem Level 3: acute uncomplicated illness (strep)
Data Level 4: Strep NAT test, U/A, and independent historian
Risk Level 4: Amoxicillin prescribed

Coding: 99214, G2211

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 (continued)

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, OR because parent wants the test. The test must only be done if medically indicated.

NOTE: parental concern does NOT support medical necessity, so you have to agree with the concern (careful with documentation), or else the test should be reported to the payor but paid for by the parent out of pocket.

Vignette #6:

7 yo female presents with 3 days of vomiting and 1 day of significant diarrhea, low energy (sleeping all day long) and stomach pains. She is tolerating only minimal fluids and mom says she has only urinated twice that day and urine is very dark. Mom is a nurse practitioner and is not an alarmist but she seems very concerned with her daughter. Her PMHx is significant for a UTI at 4yo but otherwise no concerns.

Vignette #6: (continued)

Her physical exam is significant for an ill-appearing child. Her tonsils are minimally red, her abdomen is also minimally tender, no HSM, no rebound or guarding.

Labs: Flu/Covid/strep NAT done and she is positive for strep. U/A has a specific gravity of 1030 with ketones but no nitrites or leukocyte esterase. UCx sent.

Diagnosis: strep,dehydration, vomiting, diarrhea

Vignette #6: (continued)

Plan: Amoxicillin. Patient is vomiting and struggling to keep down fluids. I discuss with mom sending her to the ER for fluids and blood work. I then call the ER and discuss the case with the attending. We decide that with a dose of zofran and amoxicillin that she may turn the corner. She was instructed to follow-up with me in the morning (it was about 5pm).

Vignette #6: (continued)

Problem Level 4: undiagnosed new problem of uncertain prognosis
Data Level 5: Category 1: independent historian and >2 tests ordered, AND Category 3: case discussed with external MD
Risk Level 5: decision regarding hospitalization

Coding: 99215, G2211

Vignette #6: FYI

Parents called the office at 730 am to say they were taking their daughter to the ER. I called the mom and serendipitously the ER attending had just finished examining the patient and we discussed a plan and labs to be done.

Labs in ER: Na=128 K=6.4 Cl= 93 CO2=14 Glucose=84 **BUN=185 Creatinine=7.1** WBC=10, Hb=9.2 Platelets=22

DX: Acute Renal Failure secondary to HUS; pt transferred for emergency hemodialysis. She was found to have shiga toxin producing E. Coli, EAEC, and sapovirus. After 2 weeks in PICU she was discharged home christmas eve. 1 year later she is doing well and nephrology is cautiously optimistic for a full recovery.

Vignette#7:

9 yo male presents for his first visit in the office for an ADHD visit. (Note: he is transferring in as mom is unhappy with the front staff at the prior pediatrician.) He was first diagnosed with ADHD 3 years ago by a neurologist but was not started on medication at that time. Last year he developed motor tics and was referred to CHOP for a full neuropsychiatric evaluation. After the evaluation, he was started on Clonidine, but that made him too sleepy so he was switched to Guanfacine 1 mg. This helped only modestly with his ADHD and he developed some lower BPs, so a stimulant was recommended. He was put on Vyvanse 10mg, then increased to 20mg. He was having some increased concentration issues in the last 2 months. In addition, mom has noted some increase in tics in the last 2 weeks.

Vignette#7: (continued)

PMHx is significant for ADHD, asthma, eczema, amblyopia, T&A with MT tubes, umbilical hernia, and patient is s/p ureteral meatoplasty. His current medications are Guanfacine 1mg, Vyvanse 20mg.
PE: wnl, no concerns

Diagnosis: ADHD, Tic Disorder

Plan: Will increase Vyvanse to 30 mg and continue Guanfecine, if an increase in motor tics is seen will decrease back to the Vyvanse 20 mg

Time: 12 min spent prior to visit reviewing records, 41 min face to face time, 7 min documenting, 4 minutes spent writing for medication (total time=64 min)

Vignette#7: Coding

Coding by time:

99205 (60 min), G2211

How would you have coded this if it wasn’t a new patient?

Vignette#7: (Coding continued)

If the was an established patient and you spent 64 min:
Coding: 99215, 99417, G2211

40 min for the 99215 + 1 unit of 99417 15min

The visit would have to be more than 70 minutes to bill an additional unit of 99417 with an established patient

Vignette #8:

21 mo old male new to the practice presents 1 day after hospital discharge for presumed febrile seizure and choking episode. He is here today because he needs medical clearance for myringotomy tube placement tomorrow. Pt was well until 2 days ago, on day of admission, when he developed a fever and had a seizure lasting about 30 seconds. Shortly after the seizure Mom drove him to the hospital but on the way he had a choking spell and then another seizure. Mom pulled over to the side of the road and called 911. He had 2 additional shaking episodes followed by full body limpness each episode lasting about 15 seconds. When EMS arrived he was no longer seizing but he was clearly in a state of altered mental status.

Vignette #8: (continued)

Patient was evaluated in the ER and found to have 106 fever, and was given Rocephin and a partial sepsis workup was done. He was admitted to the floor for observation because of his high fever with no source and multiple seizures.

His one day hospitalization was uneventful. He seemed to return to his normal mental status later that evening. All blood work was normal (CBC, CRP, CMP, and ESR) and blood and urine cultures are pending. He did have an additional fever at 2am, but no subsequent seizures. Later that afternoon he was discharged home.

Vignette #8: (continued)

The day after discharge he was seen in the office. He was back to baseline, eating, playing and acting normally. Normal PE, but he was not cleared for MT tube placement. He was not sent home on any medication. Cultures were negative to date and therefore decided not to give additional rocephin.

PMHx is significant for eczema and developmental delays and concerns of autism

DDX: febrile seizures, infection, seizure disorder

Diagnosis: seizure, fever

Vignette #8: Coding

Problem Level 4: undiagnosed new problem of uncertain prognosis
Data Level 4: mom is the historian and multiple lab results reviewed
Risk Level 4: prescription drug management (decided not to give second dose of Rocephin)

Coding: 99204, G2211 **OR** 99495 transition of care management, moderate complexity

Transition of Care Requirements

99495 (MODERATE) Transitional care management services with the following required elements:

1. Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge;
2. Medical decision-making (MDM)of at least moderate complexity during the service period
3. Face-to-face visit, within 14 calendar days of discharge

99496 (HIGH) Transitional care management services with the following required elements:

1. Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge;
2. Medical decision-making of high complexity during the service period;
3. Face-to-face visit, within 7 calendar days of discharge

Transition of Care: (continued)

Create a separate add on protocol where the following must be documented:

Informant, location of admission, medication reconciliation, DOA and discharge, procedures, summary of hospital course, and then must have contact with these above questions answered with 2 business days of discharge, and must be seen within 7 days for highly complex and with 14 days for moderately complex

Transition of Care: (continued)

Common mistakes:

1. Office visit where the MDM is only a level 3. Commonly this happens with bili babies. The MDM must be at least a level 4 to justify a TCM visit.
2. There is contact within the 48 hr window, but this is not documented, nor are any of the other requirements (eg medication reconciliation) at the time of the call

Remember, this is one of the best compensated codes in Pediatrics, so it is worth the effort! But please make sure to document meticulously in case of audit. At BCD our coding committee reviews ALL TCM visits prior to submission.

Vignette #9:

A 2 yo male presents for well visit with his mom. History and physical are performed and all appropriate counseling is done. Patient was noted to have a left ear infection on exam. The patient had not had a recent illness, just some minimal ongoing congestion.
A separate sick note is documented and Amoxicillin is prescribed.

Diagnosis: well child, left acute otitis media

Vignette #9: Coding

99392 Preventive visit for established patient 1-4 yo, 99213-25, and Z00.121 (encounter for routine child health with exam with abnormal finding) with H65.02 (Acute serous otitis media left ear)

Problem Level 3: acute uncomplicated illness
Data Level 3: mom is the historian
Risk Level 4: prescription of Amoxicillin)

Vignette #9: Notes

When can you bill a separate sick??

When the abnormality is significant enough to perform additional work to perform the key components of a problem-oriented E/M service

What about if a diaper rash was noted on a 6 month old during a well exam and zinc oxide was recommended and told to follow-up if the rash gets worse?

No, in this case no significant amount of extra work was done.

Vignette #10:

A 15 year old female presents with fever and worsening sore throat for 3 days. She was seen 2 days ago by a different doctor in the practice. A strep/covid/flu antigen tests were all negative at that visit. A throat culture was sent to the lab and you see that the negative throat culture results came in today. She is exhausted, and the pain is increasing, but patient hasn't taken any pain medication. She is drinking minimally and barely eating. She is in a significant amount of pain and talking like she has a hot potato in her throat.

Vignette #10: (continued)

Pertinent physical exam findings: Patient is in obvious discomfort. 4+ tonsils with significant exudate. Some coarse breath sounds but no wheezing or rales. Normal abdomen exam but minimal hepatomegaly noted.

Labs performed: Monospot is positive

Patient was advised to take 600 mg of ibuprofen Q6 hrs, 1000 mg of Acetaminophen Q4 hrs, and to follow up by phone tomorrow.

Steroid prescription was discussed and decided that if the patient is not doing better by tomorrow steroids would be prescribed.

Diagnosis: mononucleosis

Vignette #10: Coding

Problem level 4: acute illness with systemic symptoms (mono with hepatomegaly)
Data level 3: mom is the historian and 1 monospot (throat culture reviewed does NOT count)
Risk level 4: prescription drug management. Steroid prescription was discussed

Coding: 99214, G2211

Vignette #11:

16 yo male presents with 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 his basketball game he was struggling to dribble, he was taken out of game for poor performance (he is usually the star player). Today he states his hands feel “weird”, touch sensation is “off”, palms are tingling and numb. These sensations extend to fingers but not as severe as palms. Both hands feel equally affected. He also mentioned that his tongue feels numb, but that taste is intact. The physical exam is normal with normal fundoscopic exam, CN grossly intact, b/l hand and arm strength 5/5, but patient reports feeling weaker grip than usual. Normal pinprick test b/l. Tongue with FROM and normal appearance and reporting normal taste.

Vignette #11: (continued)

DDX: multiple sclerosis, brain tumor, psychogenic, unknown neurologic disorder

Diagnosis: Numbness of hands, Other disturbances of oral epithelium, including the tongue

Plan: Case discussed with pediatric neurologist, he agreed to see the patient the next day and he would order any necessary labs at that time

Vignette #11: Coding

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)

Coding: 99214, G2211

Vignette #12:

The mother of a 12 yo female comes in alone to discuss the need for allergy shots. The patient's past medical history includes mild eczema, and significant seasonal (spring) allergy-induced asthma. Almost annually she requires the use of oral steroids despite her significant medication regimen of flonase, zyrtec, singulair, albuterol and flovent. Her allergist has recommended allergy shots but the father is opposed to weekly visits, thinks allergy shots are a scam to get money from him, and is in general weary of the medical system. The parents are divorced and mom is unsure of what to do and seeks a second opinion. In addition, mom thinks that possibly with 2 physicians recommending the allergy shots Dad might reconsider.

Vignette #12: (continued)

We have a 16 minute conversation discussing the pros and cons of allergy shots but ultimately I do recommend going forward with the allergy shots. I call the father later that day to discuss his hesitations and see if we can all get on the same page but he is resistant. The call lasts 4 minutes.

Diagnosis: Seasonal allergies, Caregiver's noncompliance with patient's medication regimen, Disruption of family by separation or divorce

I spend 4 min documenting my note. Total time 24 minutes. Would you code this by time or MDM?

Vignette #12: Coding

Coding by time: 99213, G2211
Total face-to-face time 16 min, call with Dad 4 min, documentation 4 min; total time=24 minutes

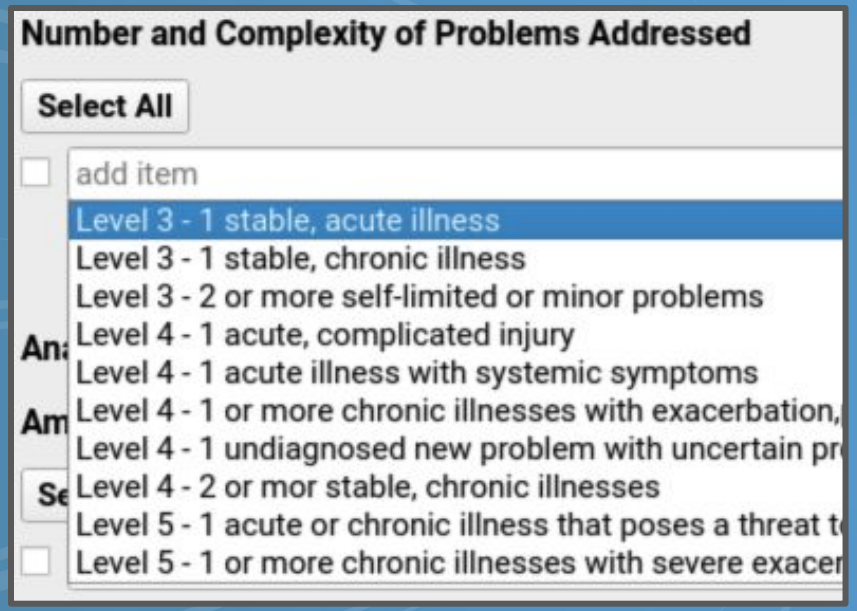
Coding by MDM: 99214, G2211
Problem Level 4: seasonal allergies, Chronic illness with exacerbation or progression
Data Level 3: Mother is the historian
Risk Level 4: Treatment significantly limited by social determinants of health

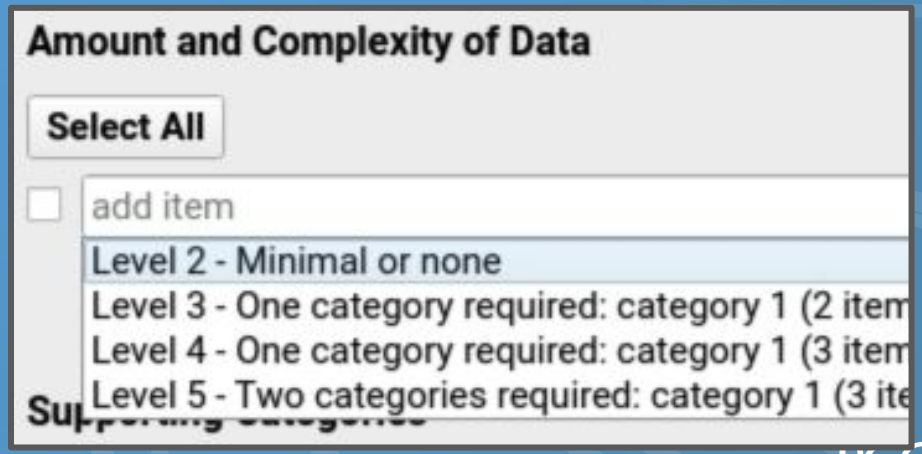
BCD Health Partners' Approach to Coding Documentation

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 helps BCD with internal auditing to ensure the providers understand proper coding
3. Billers can easily dispute denials or rejected claims (they literally cut and paste our MDM section into claim disputes)

BCD Health Partners' Approach - Problems





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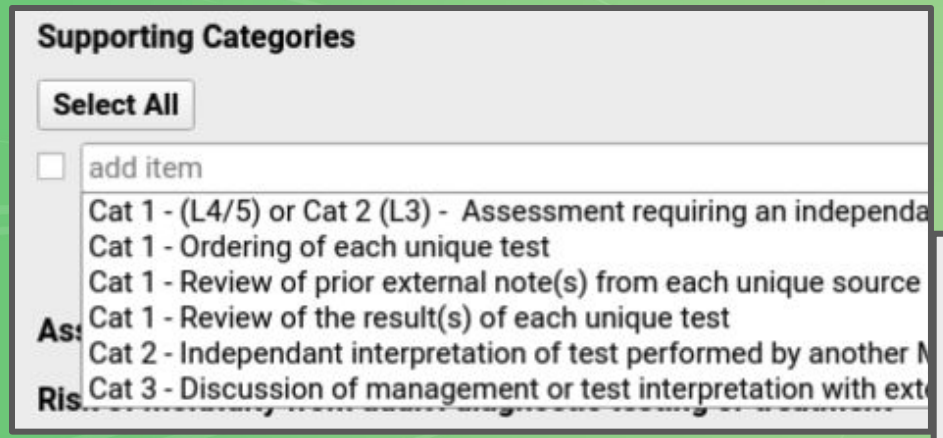
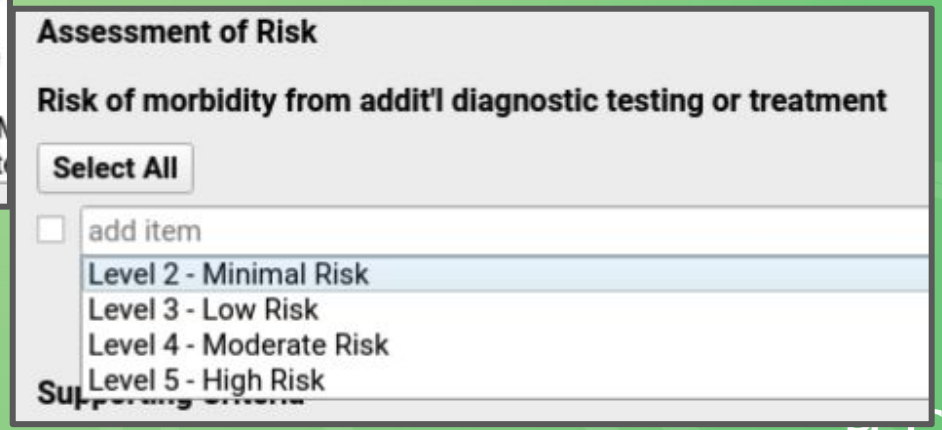
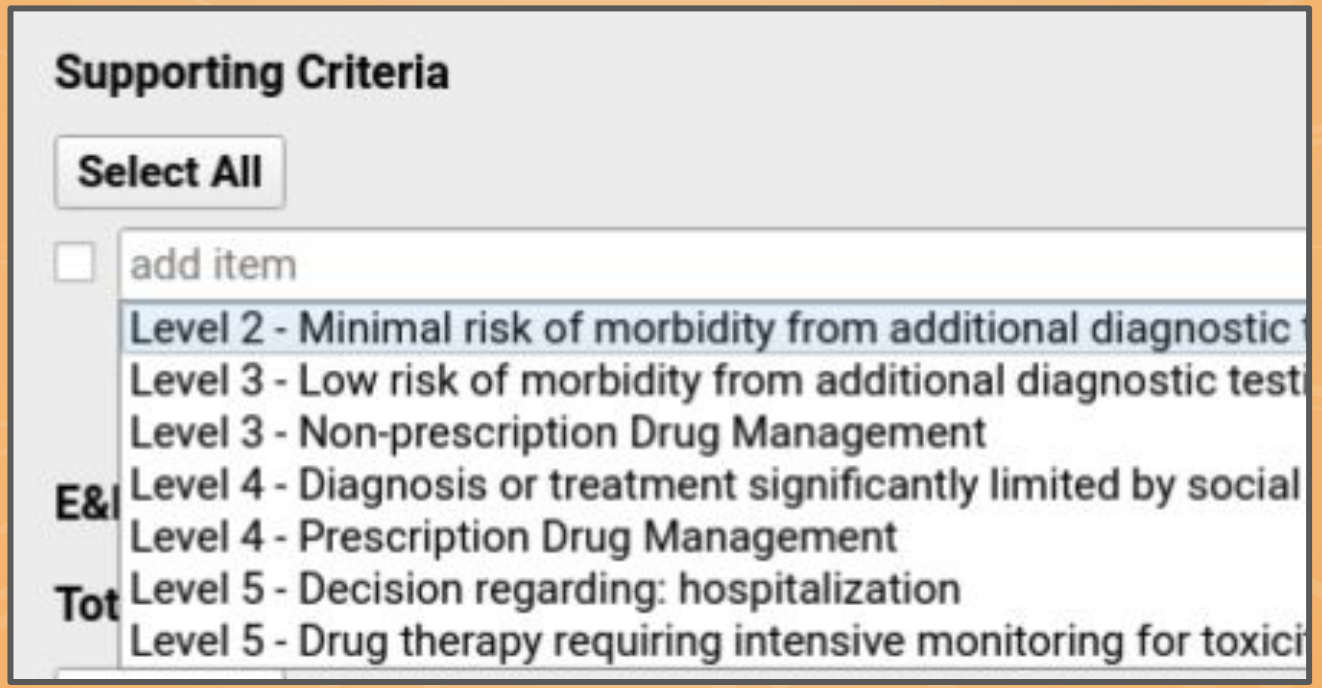
BCD Health Partners' Approach - Data Categories





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 a thorough history and physical that accurately reflects 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.

Session Takeaways

1. Use judgment for MDM leveling or the clock for time
2. Level based on your experience *and documentation*
3. Document your experience throughly

What Questions Do You Have?

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2024 CPT Updates - PLA Codes

Proprietary Lab Analysis Codes

- Labs or manufacturers apply for these CPTs to more specifically identify their test
- Appendix O in CPT
- Per AMA, these take precedence over other CPTs and should NOT be reported with other Category 1 CPTs

References

Links

What Questions Do You Have?