Coding Guidelines, Modifiers and Billing Tips for the Pediatric Primary Care Provider

Alyssa A. Riley, MD, MEd, ACPA-C

Director, CDI & Financial Integrity

Objectives

1. Understand how recent coding updates impact documentation
2. Accurately report your work with respect to:
   - Time
   - Medical Decision Making (MDM)
   - Modifier -25
3. Review quick opportunities for documentation improvement

A Case to Started

An 11-yr old boy (est pt) is seen for a WCC. During the visit, you note marked congested, and learn he had a flu-like illness onset 10 days prior that resolved after 4-5 days and has 2 days of intermittent fevers (Tmax 101F) and headaches.

His well care is completed, and you prescribe 10 days of oral amoxicillin to treat sinusitis

9 minutes are spent to assess, manage & document sinusitis.

What code(s) would you assign for this visit?

What code do you select?

- 99393 (Preventative Visit 5-11 yr)
- 99213 (Level 3 E/M)
- 99214 (Level 4 E/M)
- 99393 + 99213-25
- 99393 + 99214-25
- Something else

STRONG Documentation

- Identifies suspected/confirmed primary diagnosis
- Characterizes ACTIVE **and** CHRONIC diagnoses
- Describes medical necessity
- Describes plan of care
- Supports your professional code reporting
- Document & code to the highest degree of specificity

(We typically do MORE than we DOCUMENT!)

Visit Leveling: Time vs MDM

2021 CMS change:

Use Medical Decision Making (MDM) or Time definitive to determine the level of service

- Need medically appropriate history & physical exam

Changes intended to
decrease documentation burden
& focus on documenting MDM

Document everything medically relevant!

Time-Based E/M Services

	Code	MDM	Time
New Patient	99202	Straightforward	**15 min**
	99203	Low	**30 min**
	99204	Moderate	**45 min**
	99205	High	**60 min**
Established Patient	99212	Straightforward	**10 min**
	99213	Low	**20 min**
	99214	Moderate	**30 min**
	99215	High	**40 min**

Time includes:

- Visit prep
- Obtaining history
- Performing exam
- Counseling family
- Orders
- Communications
- Documentation
- Interpreting result (not separately reported)
- Care coordination (not separately reported)

Total Time

Activities that may be counted in total time on the same day

- Preparing to see the patient (review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing medically appropriate examination
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring/communicating with other health care professionals (When not separately reported)
- Documenting information in the EMR
- Independently Interpreting results (if not reported separately) and communicating results to the patient/family/caregiver
- Care Coordination (if not reported separately)

Activities that may NOT be counted in time on the same day

- **Documenting the day before the encounter**
- **Reviewing chart notes the day before**
- **Documenting the day after the encounter**
- Time spent by clinical staff cannot be counted
- Resident/fellow time spent does not count
- **The performance of other services that are reported separately**
- **Travel**
- **Teaching that is general & not limited to discussion that is required for the management of a specific patient**

Prolonged Service

- Report add-on code +99417 when total time for the Primary Service exceeds the highest-level service definitive time by at least 15 minutes
  - Separately reported services do not count towards the total
  - New Patient: 99205 + 99417 if ≥75 minutes
  - Established Patient: 99215 + 99417 if ≥55 minutes
- Report a unit of +99417 for ***each*** 15-minute increment of care

Prolonged Service Times

INPATIENT	Code	CPT Code
New Patient 99205/Level 5*	75-89 min	99205 and +99417 x1
	90-104 min	99205 and +99417 x2
	105 min or more	99205 and +99417 x3 or more per 15 min
Established Patient 99215 /Level 5*	55 – 69 min	99215 and +99417 x1
	70 - 84 min	99215 and +99417 x2
	85 min or more	99215 and +99417 x3 or more per 15 min

*CMS Medicare codes & time ranges may differ.

Time Based Services – Prolonged Service

- A provider spends ***10 minutes*** before an established patient visit reviewing the patient's medical record.
- ***40 minutes*** are spent face-to-face with the patient and parents.
- After the visit, ***10 minutes*** is spent finishing documentation on the same day.

- The total time spent on the *day of encounter* is ***60 minutes***

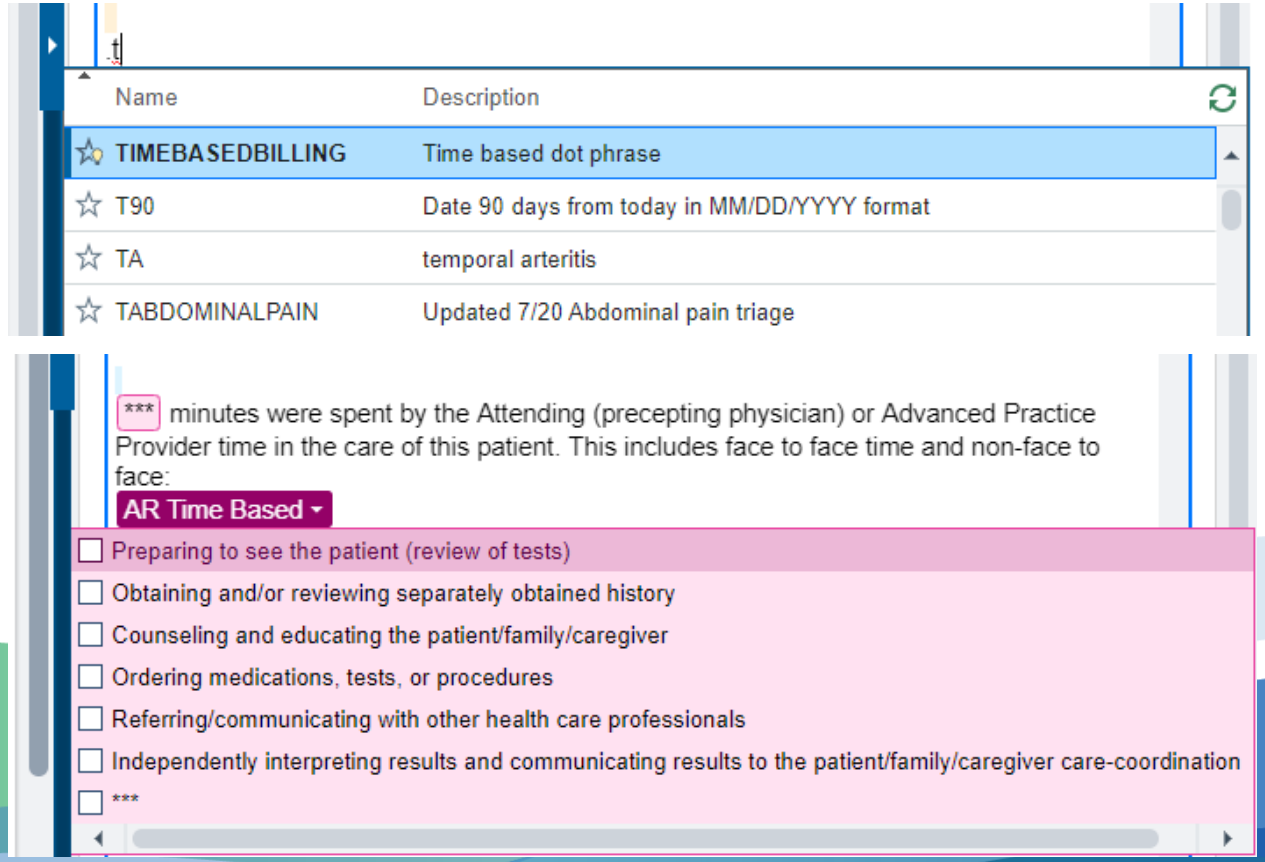
- **What CPT code(s) should be reported?**
  REPORT: 99215 with +99417 x 1 unit

Tips on Time Based Services

- Code by TIME when your total patient care time exceeds the appropriate MDM level
  - If Time Based billing, ALWAYS document TIME in your note
  - Do not report TIME if using MDM as key driver
- Time documented must be reasonable
  - Your workday total cannot exceed 24 hours
- Document what your time was spent doing
- All activity reported for time **must** be on the day of service

Summarize Your Time

- Create a dotphrase
- EPIC example -> .TimeBasedBilling



Medical-Decision-Making Based Billing

1. **Problems:** Establish diagnoses with severity
   - The number & complexity of ***problem(s) addressed during the encounter***

2. **Data:** Assessing condition(s) status
   - Amount and/or complexity of ***data to be reviewed and analyzed***

3. **Risk:** Selecting management option(s)
   - The ***Risk*** of complications, morbidity and/or mortality of patient management decisions made at the visit

Level of MDM is based on meeting 2 out of 3 level elements to determine the overall level of service

Code (Refer to description on reverse)	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
Level 2 **99202** **99212** **99242**	**Straight-forward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Level 3 **99203** **99213** **99243**	**Low**	**Low** • **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.	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** -Review of prior external notes(s) from each unique source*; -Review of the result(s) of each unique test*; -Ordering of each unique test*. **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or testing**
Level 4 **99204** **99214** **99244**	**Moderate**	**Moderate** • **1** or more ch progression, o **or** • **2** or more st **or** • **1** undiagnose prognosis; **or** • **1** acute illnes **or** • **1** acute, com	qualified health care professional/appropriate source (not separately reported).	**f morbidity from additional diagnostic nent** drug management; rding minor surgery with identified dure risk factors; rding elective major surgery without t or procedure risk factors; treatment significantly limited by nts of health.
Level 5 **99205** **99215** **99245**	**High**	**High** • **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.	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian(s).** • **Any combination of 3 from the following:** -Review of prior external note(s) from each unique source*; -Review of the result(s) of each unique test*; -Ordering of each unique test*; -Assessment requiring an independent historian(s); **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported).	**High risk of morbidity from additional diagnostic testing or treatment** *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 because of poor prognosis; • Parenteral controlled substances.

At least 2 elements need to meet level criteria to select that level of service

Medical Decision Making (MDM) - Problems

- **Problems Addressed** (1st column)
  - Actively treated or considered issues
  - Include a chronic condition if:
    - Addressing it as a problem
    - Condition increases risk or complicates the main problem(s)

Document every diagnosis you are considering as a 'problem addressed'
The "Problem List" DOES NOT COUNT

Medical Decision Making (MDM) – Data

- **Amount and Complexity of Data Reviewed or Analyzed**

(middle column)

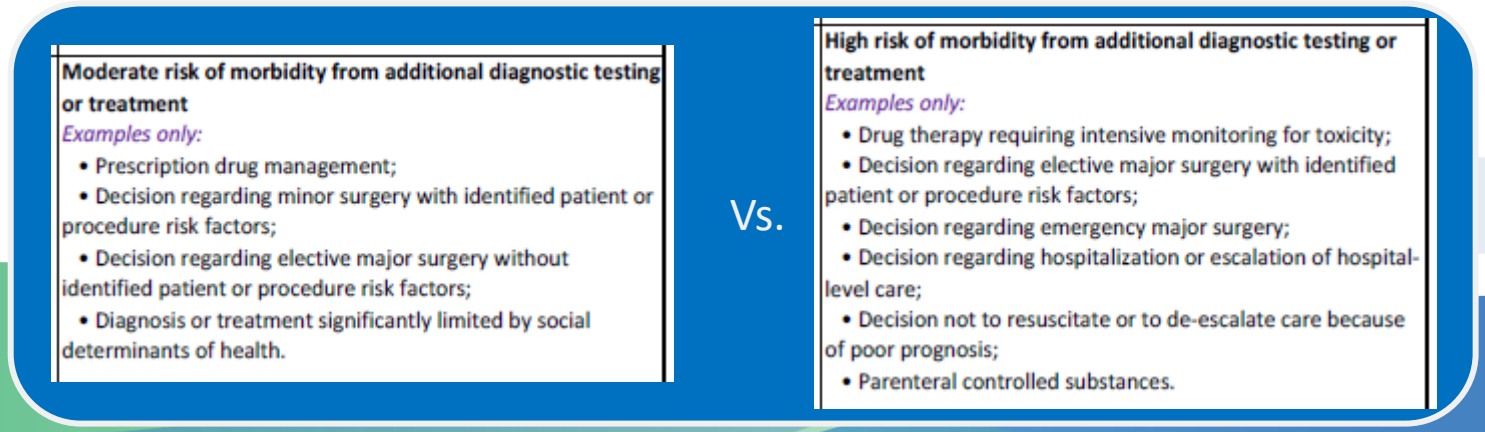
  - Each unique test, order, or document contributes to the combination of 2 or 3 based on the level
  - Your interpretation of the test (e.g. CXR, EKG)
  - Your discussion with other qualified professionals

To "get credit" you must document:

- The test(s) ordered
- Who the independent historian is
- Your interpretation of the test (e.g. CXR, EKG)
  - "I independently interpreted…"
- Your discussion with other qualified professionals
  - Trainee discussions with consultants do not count

Medical Decision Making (MDM) – Risk

- **Risk** (Last column)
  - The potential consequences of a problem or treatment
  - Escalating or de-escalating level of care
  - Consideration, but may not necessarily do
  - ****Document your decision making****



Medical Decision Making (MDM) - Straightforward

	MDM Elements		
Level of MDM	# and Complexity of Problems Addressed	Amount and Complexity of Data Reviewed or Analyzed	Risk of Complications, morbidity, mortality
Straight-forward	1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

A patient presents with a small area of uncomplicated heat rash. The patient's parents are advised on home care.

Medical Decision Making (MDM) - LOW

	MDM Elements		
Level of MDM *Need 2 of 3 MDM elements*	# and Complexity of Problems Addressed	Amount and Complexity of Data Reviewed or Analyzed	Risk of Complications, morbidity, mortality
Low	2 minor problems **OR** 1 stable chronic illness **OR** 1 acute complicated illness **OR** 1 stable acute illness **OR** 1 acute uncomplicated illness requiring hospitalization	Must meet requirements of **1 of the 2** following categories: **Cat 1:** tests and documents *(need 2):* - Review of prior, unique, external source of info - Order a test - Review test result **Cat 2:** independent historian	Low risk: - OTC med - PT/OT

A patient presents with URI symptoms and a low-grade fever. A rapid flu test is negative. The parents are advised they can use Tylenol for discomfort/fever.

Medical Decision Making (MDM) - MODERATE

	MDM Elements		
Level of MDM *Need 2 of 3 MDM elements*	# and Complexity of Problems Addressed	Amount and Complexity of Data Reviewed or Analyzed	Risk of Complications, morbidity, mortality
Moderate	1 chronic illness with exacerbation **OR** 2 or more stable chronic illnesses **OR** 1 new problem, uncertain diagnosis **OR** 1 acute illness with systemic symptoms **OR** 1 acute complicated injury	Must meet requirements of **1 of the 3** following categories: **Cat 1:** tests & documents, indep historian *(need 3):* - Review of each prior, unique, external source of info* - Order each unique test* - Review each unique test result* - Independent historian **OR** **Cat 2:** Independent interpretation of tests **OR** **Cat 3:** discussion of management or test interpretation with qualified professional	Moderate risk: - Rx drug - Minor surgery *with* risk factors - Major elective surgery *without* risk factors - SDoH significantly affecting Dx or treatment

A patient presents 1 week after a URI with ear pain and fevers (Tmax 102F). A bulging TM is seen on exam. Oral acetaminophen or ibuprofen is advised Tylenol for discomfort/fever, and oral amoxicillin is prescribed for right AOM.

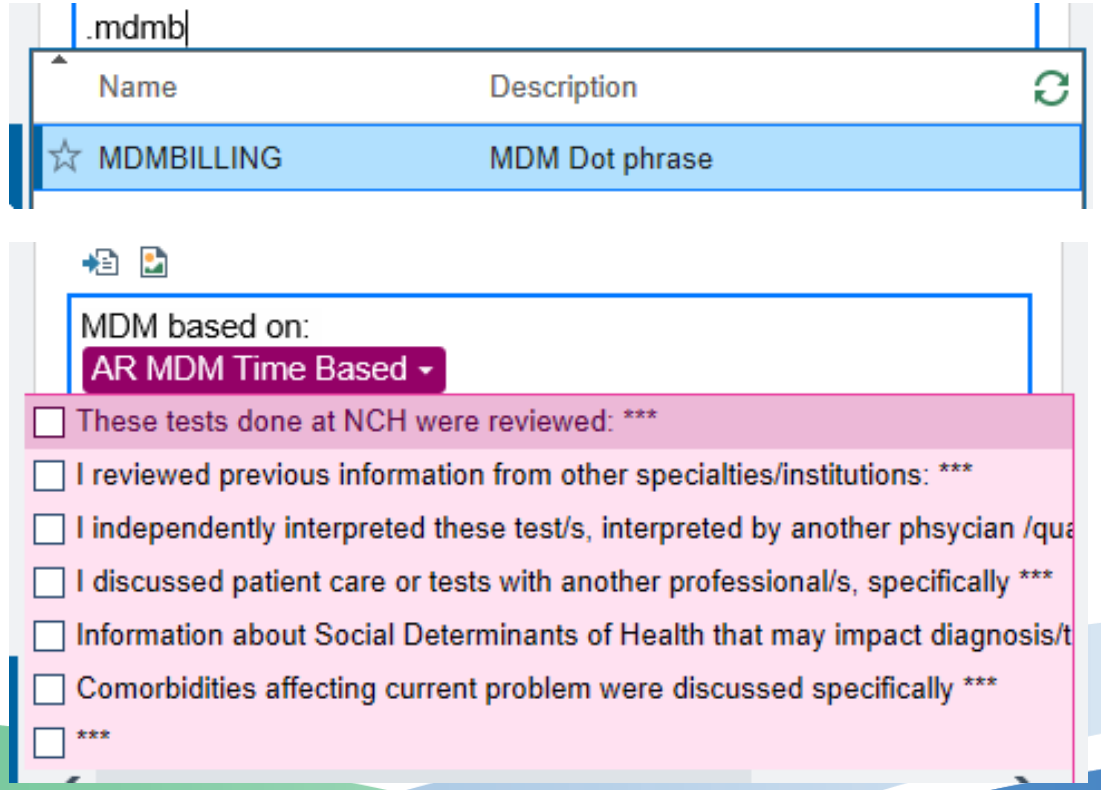
Medical Decision Making (MDM) - HIGH

	MDM Elements		
Level of MDM *Need 2 of 3 MDM elements*	# and Complexity of Problems Addressed	Amount and Complexity of Data Reviewed or Analyzed	Risk of Complications, morbidity, mortality
High	1 chronic illness with severe exacerbation **OR** 1 acute illness posing threat to life or bodily function	Must meet requirements of **2 of the 3** following categories: **Cat 1:** tests & documents, indep historian *(need 3):* - Review of each prior, unique, external source of info* - Order each unique test* - Review each unique test result* - Independent historian **OR** **Cat 2:** Independent interpretation of tests **OR** **Cat 3:** discussion of management or test interpretation with qualified professional	High risk: - Drug therapy monitoring for toxicity - IV controlled substance - Major elective surgery *with* risk factors - Decision to hospitalize or escalate hospital LOC - Decision to DNR or de-escalate care due to poor prognosis

Patient is seen for significant respiratory distress with congestion, fever, poor oral intake. Pt is hypoxic (SpO2 88%) with decreased RLL breath sounds. Supplemental oxygen is started in clinic and EMS is contacted for transport to a pediatric ED.

Summarize Your MDM

EPIC Example -> .MDMBilling



Recap: Billing Based on MDM or Time

MDM

Based on Highest 2 of 3 Elements

- ☐ Number & Complexity of Problems Addressed during the E/M encounter
- ☐ Amount and/or Complexity of Data to be Reviewed and Analyzed
- ☐ Risk of Complications, Morbidity and/or Mortality of Patient decisions made at the visit

OR

Time

Total Time Spent on DOS

- ☐ Represents total physician or other qualified health care professional (QHP) time on the date of service.
- ☐ Time includes all professional face-to-face and non-face-to-face time of the provider, performing medically appropriate exam, discussion with patient/family, reviewing records, ordering tests, time spent in documentation on same date, care coordination, etc.
- ☐ Resident/Fellow time spent does NOT count

Modifier -25

- Significant, separately identifiable E/M services performed on the same day of a procedure or other service by same physician
  - i.e. Perform and report a preventative medicine service with a problem-oriented service
- Common usages to add modifier -25
  - Preventative visit (WCC) billed with a sick/office visit
  - E/M visit with a procedure
  - E/M visit with vaccines
  - E/M visit with developmental/behavioral/caregiver screening(s)

Modifier -25 is never appended to a procedure or a screening or a non-E/M service

Modifier -25

- Separate, supporting documentation is required for the E/M service and the procedure/other service
  - *May be on same progress note, but each should be distinct*
- Different diagnoses are not required for reporting E/M services on the same date
- CPT procedure codes include evaluative elements routinely performed prior to a procedure and routine postoperative care.
  - *An assessment of the problem with an explanation of the procedure is considered inherent to the procedure and should not be reported separately with an E/M*
- Modifier -25 should only be appended to the E/M CPT code
- When appropriate, modifier -25 may be reported on more than one E/M service for a single encounter

Modifier -25: Example

A 7-year-old girl is seen for her preventative medicine visit. All necessary components of a preventative medicine E/M visit are provided, including hearing and vision screening, appropriate laboratory tests and immunizations. She also has a diagnosis of ADHD and is on a stimulant. During the preventative office visit, the ADHD is also evaluated with parent concerns addressed, which warrants a medication increase to due uncontrolled symptoms, and follow-up arranged in 1 month.

REPORT: Preventative Visit 99393 AND 99214-25

*RATIONALE: Documentation supports both the preventative visit **and** that the physician separately spent additional time in counseling for the ADHD, addressing parent concerns and behavior management.*

Modifier -25: Usage Guidance

- The medical record must support both services.
- An insignificant or trivial problem/abnormality encountered in the process of performing the preventive medicine evaluation and management service (e.g., minor diaper rash, renewal of prescription medications, minor cold, stable chronic problem) and which does not require additional work and the performance of the key components (history, physical, MDM, or time) of a problem-oriented E/M service should not be reported..
- When the E/M Service is a routine part of the usual preoperative/ postoperative care then a modifier should not be reported.

Modifier -25:

Preventive Medicine with Office Visit Documentation

- Document the WCC & any anticipatory guidance, risk factors, etc
- If a significant issue or abnormality is brought up during the preventive visit, document medically appropriate history/exam and the MDM/plan of treatment

- You do not have to create a separate note in the EMR
  - You can add the office visit documentation at the end of your note
  - Recommend adding as a clearly labeled separate section of same note

A 10-yr-old established pt is seen for his preventative medicine visit. The pt's mother describes increased asthma symptoms, requiring dosage adjustment of the pt's control medication.

What code(s) do you report?

Z00.121 (WCC w/ abnormal finding)
J45.40 (moderate persistent asthma, uncomplicated)

CPT 99393

CPT 99214-25

An 8-yr-old girl with treated GERD is seen for a preventative medicine visit. Her mother reports symptom improvement since the medication was started and requests a prescription refill. There are no new abnormal findings. An order for the medication refill is placed in addition to providing the preventative E/M service.

What code(s) would you report?

Z00.129 (WCC without abnormal findings)
K21.9 (GERD without esophagitis)
CPT 99393

CPT Code* with Time & Vignette (also report appropriate preventative service)	No. & Complexity of Problems Addressed	Amount and/or Complexity of Data Reviewed & Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99212 (10-19 min) An infant is evaluated & found to have seborrheic capitis.	**Minimal:** Self-limited problem	**Limited**: Assessment requiring an independent historian(s)	**Minimal**
99213 (20-29 min) A 14-yr old present for a rash on their forearms. Diagnosis is poison ivy.	**Low**: 1 acute, uncomplicated illness or injury	**Minimal or none**	**Low**: Home management with OTC products
99214 (30-39 min) A child present with new-onset rash, with fever and sore throat in the past week.	**Moderate**: Acute illness with systemic symptoms and high risk of morbidity without treatment	**Moderate**: Streptococcal test performed. Assessment requiring an independent historian(s)	**Moderate**: Prescription of antibiotic for treatment for streptococcal sore throat.
99215 (40-54 min) 14-yr old presents for a previously scheduled WCC, expresses recent-onset anxiety with palpitations & depression, for which they are seeing a therapist. Pt describes suicidal ideation without plan or intent. Mother provides FHx, negative for BPAD & positive for anxiety disorders.	**High**: 1 acute or chronic illness or injury that poses a threat to life or bodily function	**High**: Independent historian. Tests are ordered (CBC, CMP, thyroid function, EKG). Phone d/w therapist re: prescription of SSRIs	**Moderate**: Prescription drug management

Continuum Model for Problem-Oriented & Preventative E/M on the Same Date

* Established patient assumed for illustrative purposes

Office Procedures – With CPT Code

- If the procedure has a reportable CPT code, evaluation elements performed before and after a procedure are considered inherent to the procedure:

Abscess incision & drainage
Skin tag removal
Chemical cauterization
Laceration repair, sutured
Foreign body removal, incised
Urinary catheterization
Gastrostomy tube replacement
Impacted cerumen removal
Casting / splinting
Injections / infusions

- You may add an E/M code with modifier -25 **IF** there is additional patient management

Office Procedures – No CPT Code

- Office procedures that do not have separate CPT codes:
  - Insertion or removal of an ear wick
  - Removal of *nonimpacted* cerumen from the ear
  - Nasal aspiration
  - NG tube insertion w/o fluoro guidance
  - Removal of an umbilical clamp
  - Foreign body removal w/o incision
  - Abscess puncture w/o aspiration
  - Wound closure with adhesive strips
  - Fluorescein dye & Wood lamp to examine corneal abrasion

Monitor your TIME when performing visits with minor procedures

Quick Improvements #1

When a definitive condition is present, ICD-10 symptoms codes are unnecessary

- *Example*: Evaluation of fever & sore throat
  - RST confirms Strep throat
  - Strep throat is a final diagnosis

Quick Improvements #2

Using compliant documentation for vaccine counseling

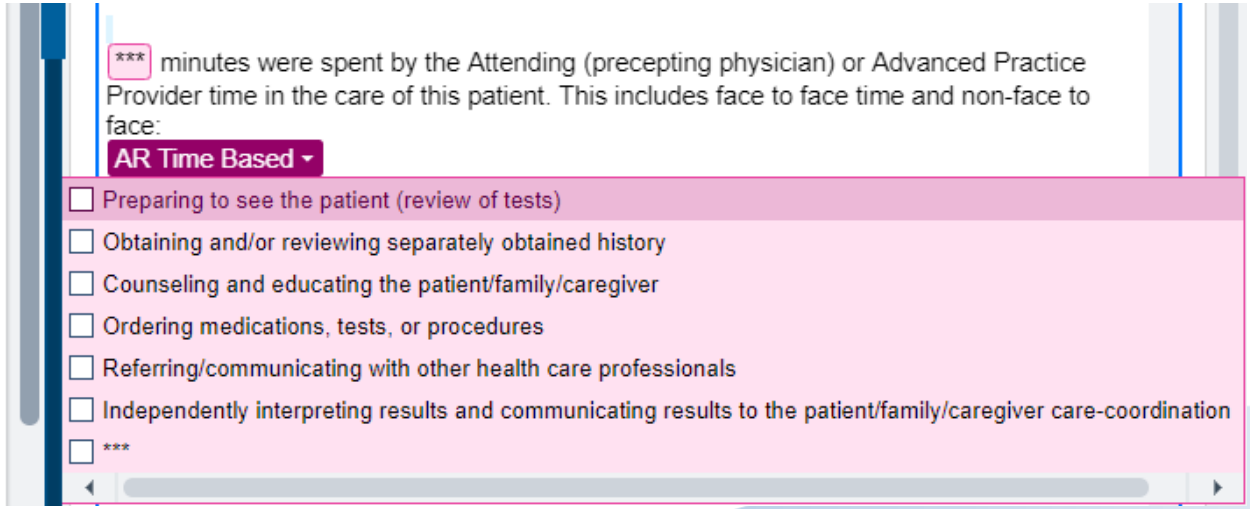
- Create/use a dotphrase:

  I have performed vaccine counseling and answered all questions from the patient and parents(s) on risks and benefits for all vaccine components.

Quick Improvements #3

Document TIME in the note when using Time Based Billing

- Create/use a dotphrase:



Quick Improvements #4

Use Z00.121 Encounter for routine child health examination with abnormal findings (Instead of Z00.129)

- Examples for when to use:
  - Identification of a new URI
  - A new cardiac murmur is heard
  - Exacerbation of a current chronic condition

Quick Improvements #5

Provide documentation supportive for the level of service

- 2 acute, uncomplicated illnesses usually do not constitute a moderate problem
  - Example: URI & UTI are typically low presenting problems
    (*given UTIs are not a chronic problem)*

- 1 acute illness with systemic symptoms as defined by the AMA:

  "An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for self-limited or minor problem or acute, uncomplicated illness or injury. Systemic symptoms may not be general but may be single system."

  - Potential examples are highly dependent on documentation!

QUESTIONS?

MERCYHEALTH

Thank you!!

Alyssa.Riley@NationwideChildrens.org

MERCYHEALTH

Our Mission

We extend the compassionate ministry of Jesus by improving the health and well-being of our communities, and bring good help to those in need, especially people who are poor, dying and underserved.

Our Values

Human Dignity | Integrity | Compassion | Stewardship | Service