Getting It Paid For!

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Slides adapted from work by various Reach contributors

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Disclosure

Dr Lashley is a partner of Allied Pediatrics of NY, a partnership of over 130 pediatricians based mostly on Long Island
Using Time to Code a Visit

If counseling and coordination of care is >50% of a visit, then time alone can be used to determine the E/M Code.
Using Time

• Time Benchmarks for a visit: Document time in, time out, total counseling time, matters discussed
  • 99212 10 minutes
  • 99213 13 minutes
  • 99214 22 minutes
  • 99215 33 minutes
How to write a note based on Time

• Only HPI and Impression/Plan are needed.
• On PE consider filling in the psych system eg: alert, mood, eye contact, appropriate interaction
• Detail the problem in HPI, use the appropriate Diagnosis: ADHD, Depression, Anxiety etc.
• Detail what was discussed in your treatment plan and counseling
How to write a note based on Time

• HPI: Jane is here for symptoms of inattention and school difficulty. She is in 2nd grade and getting complaints from teachers, and having academic failure. She often needs to be redirected and is disorganized etc….

• ROS: denies anger issues, staring spells

• Imp/Plan: After review of symptoms and Conner’s, Pt is diagnosed with ADHD Inattentive Type. Parents and pt were counseled on how diagnosis is made and treatment plan consisting of: etc.

• Time in: 9am, time out 9:50am, time counseling 26min total time 50min (99215)
Using Time

• Don’t be afraid to code a level 5 visit if indicated

• 99354 is an add on code to 99215 if a visit lasts an additional 30 minutes (total 70 minutes)

• Document: Time in, Time out, total counseling time, matters discussed and plan

• NPs and PAs cannot code by time
Example of an inadequate note

• HPI: Jane is inattentive and is failing in school

• IMP: ADHD, start a stimulant, counseled patient
• Start concerta
• Counseling >50%
## Prolonged Services

<table>
<thead>
<tr>
<th>Direct Patient Care</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-Face</td>
<td>99354: first 30-74 min</td>
</tr>
<tr>
<td>Face-to-Face</td>
<td>99355: each add 30 min &gt;75</td>
</tr>
<tr>
<td>Before or after Face-to-Face</td>
<td>99358: first 30-74 min of non</td>
</tr>
<tr>
<td></td>
<td>face-to-face</td>
</tr>
<tr>
<td>Before or after Face-to-Face</td>
<td>99359: each add 30 min &gt;75</td>
</tr>
</tbody>
</table>
Treating Mental Health at a Well Visit

• Document and code your well visit (99391-99395).
• Make a separate note about the mental health issue
• Also Code 99212-99215 use modifier -25
• Document time counseling on Mental Health issues, matters discussed, plan
Visits and Time must meet a standard

Example: If a visit lasted around 15 minutes (99213) and counseling (and minimal care coordination) was not > 50% of the total time of the visit, time cannot be appropriately used for coding AND would be coded like any other visit.

Time in: 3:02pm
Time out: 3:17pm
Time counseling 7 min
Coding without Time

• When coding an E/M visit the main determinant of the level of service is the complexity of Medical Decision Making (MDM).
• MDM complexity must reflect the level of service despite other documentation.
Clues for Highly Complex Medical Decision-Making (MDM)

- High risk for morbidity: e.g. autism; bipolar depression; mental retardation
- Laboratory or other diagnostic tests requiring review
- Extensive differential dx. to consider – List DDX or discussion.

Proper documentation of the visit is the cornerstone of justifying the use of any specific E/M code.
# Elements of Complexity: Established Patient (Meet 2/3)

<table>
<thead>
<tr>
<th>Code (Time)</th>
<th>99211 (5 m)</th>
<th>99212 (10 m)</th>
<th>99213 (15 m)</th>
<th>99214 (25 m)</th>
<th>99215 (40 m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDM</td>
<td>N/A</td>
<td>Minimal # dx, data, risk</td>
<td>Limited # dx, data Risk: low</td>
<td>Dx: multiple Data: mod. Risk: mod.</td>
<td>Dx: extensive Data: Extensive Risk: high</td>
</tr>
<tr>
<td>HX (meet 3/3)</td>
<td>N/A</td>
<td>HPI: 1-3 ROS: 0 PFSH: 0</td>
<td>HPI: 1-3 ROS: 1 PFSH: 0</td>
<td>HPI: 4+ ROS: 2-9 PFSH: 1</td>
<td>HPI: 4+ ROS: 10+ PFSH: 2</td>
</tr>
<tr>
<td>Exam</td>
<td>N/A</td>
<td>1 body area/organ system</td>
<td>Limited affected body area/organ + 1 other related</td>
<td>Extended affected body area/organ system and other related</td>
<td>8+ organ system or complete exam of a single organ system</td>
</tr>
</tbody>
</table>
Well Visit with E/M Code

- 99383 5y-11y Preventive
- 99214-25 (2/3)
  - HPI: 4+ elements
  - ROS: 3
  - PFSH: 3
  - Exam: Was part of preventive service
  - MDM: Moderate severity
Procedures

• 96127-Brief Mental Health Assessment
• Do Not use 96110 any more for these
• May be charged alone without a visit, but documentation and report is needed.
• Use for: Vanderbilts, Columbia, SCARED, PSC etc…
• May use multiple units
Rating Scales

• Must be standardized
• Informal checklists don’t qualify
• Ex: ASQ-SE, PEDS, M-CHAT, Vanderbilt ADHD, SCARED, PSC, PHQ-9, Connor’s ADHD, CBCL, BASC-2, BRIEF, CDS
• May assign one unit of 96127 for each form completed, scored, interpreted and noted in the medical record
Using 96127 w/ E/M

• Most insurer’s computer software requires a modifier to get the procedure 96127 through their system
• Modifier -25 must be appended to the E/M code
• May be billed independently from a visit- document the score and interpretation.
Modifiers (for our use here)

• -25: Significant, separately identifiable E/M service by the same physician on the same date of the procedure or other service (This is the modifier you use when you find an acute problem during a well check-up, or give any vaccine!)
Coding well with Sick

- 99383
- 99214-25
- (2) 96127 (PSC, SCARED)

This is for insurers who allow -25 and multiple units of a procedure
Good News!: Non Face-to-Face Codes

- 99339-99340: Home Care Plan Oversight
- 99358: Prolonged Service Not Face to Face relating to a prior visit
Domicillary/ Home Care Supervision
99339

• Recurrent physician supervision of a complex patient or pt. who requires multidisciplinary care and ongoing physician involvement
• Non-face-to-face
• Reflect the complexity and time required to supervise the care of the pt.
• Reported separately from E/M services
• Reported by the MD who has the supervisory role in the pt’ s. care or is the sole provider
• Reported based on the amount of time spent/calendar month
Domiciliary/ Home Care Supervision

• Services less than 15 minutes reported for the month should not be billed

• 99339: 15-29 minutes/month

• 99340: greater than 30 minutes/month
Domiciliary/ Home Care Supervision

• Services might include:
  • Regular physician development and/or revision of care plans
  • Review of subsequent reports of patient status
  • Review of related laboratory and other studies
  • Communication (including telephone care) for purposes of assessment or care decisions w/ healthcare professionals, family members, legal guardians or caregivers involved in patient care
  • Integration of new information into the medical tx. plan and/or adjustment of medical tx.
  • Attendance at team conferences/meetings
  • Development of extensive reports
Domiciliary/ Home Care Supervision

• Services NOT included in care plan oversight:
  • Travel time to and from the facility or place of domicile
  • Services furnished by ancillary or incident-to staff
  • Very low-intensity or infrequent supervision services included in the pre- and post-encounter work for an E/M service
  • Interpretation of lab or other dx. studies associated w/ a face-to-face E/M service
  • Informal consultations w/ health professionals not involved in the pt’s care
  • Routine post-operative care
# Home Care Plan Oversight Log

<table>
<thead>
<tr>
<th>Date Last Appt.</th>
<th>Date of Service</th>
<th>Service</th>
<th>Action After Service</th>
<th>Time</th>
<th>Total Time/ Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/8/10</td>
<td>2/20/11</td>
<td>TC: Talked w/mother re: severity of sx's</td>
<td>Offered to see Nora</td>
<td>12 min.</td>
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<td></td>
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</tr>
<tr>
<td>2/8/10</td>
<td>2/21/10</td>
<td>TC: Explained need for scale to teacher</td>
<td>Waiting for scales</td>
<td>13 min.</td>
<td></td>
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<tr>
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<td></td>
</tr>
<tr>
<td>2/8/10</td>
<td>2/24/10</td>
<td>Reviewed Teacher scale</td>
<td>Moved up Nora’s appt.</td>
<td>4 min.</td>
<td>29 min.</td>
</tr>
</tbody>
</table>
How often can you follow up?

• Remember, a chronic condition, such as ADHD or depression, managed on an ongoing basis may be coded and reported as many times as applicable to the patient’s treatment.

• The level of the E/M visit may change as the complexity of the child’s needs change.
CPT Updates

• Documentation guideline revisions by CMS and AMA: [www.cms.hhs.gov/MLNProducts](http://www.cms.hhs.gov/MLNProducts)

• AAP updates on these: [www.aap.org](http://www.aap.org); AAP News; AAP Pediatric Coding Companion newsletter

• AACAP updates published in their newsletter
References


References


- RUC Database: [www.catalogue.ama-assn.org](http://www.catalogue.ama-assn.org) or call 800/621-8335
Resources

- www.aap.org/sections/schoolhealth
- www.aap.org/mentalhealth
- www.aacap.org
- www.schoolpsychiatry.org

Lwegner@med.unc.edu
Thank you

Questions?
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