Advancing Asthma Care: A PHN Initiative – Educational Webinar #1

Asthma Update 2021: New NHLBI Guidelines and Coding & Billing for Asthma Services

Speakers: Eduardo Fox, MD ; Shilpa Patel, MD, MPH ; Sandy Chung, MD

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A few notes about today's webinar:

- All lines are muted throughout the presentation.
- Please use the Q&A function to ask questions or make comments during the presentation
- We will be recording the session.
- Today's recording and materials will be posted to PHN's virtual collaboration site, Glasscubes, and the Advancing Asthma Care page on PHN's website following the presentation.

Agenda

1. Brief overview of Advancing Asthma Care: A PHN Initiative
2. Review how to access practical tools in new NHLBI Asthma Guidelines, including newly formatted Asthma Action Plan
3. Review updated therapeutic guidelines for children with asthma
4. Review billing and coding changes and learn how to optimally bill for asthma care

Advancing Asthma Care: A PHN Initiative

Global AIM

Identify and optimally manage your population of patients with persistent asthma

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IMPACT DC

Improving Pediatric Asthma Care in the District of Columbia

Menu of Asthma Measures

Practices are requested to select at least **2 of the 8** measures

1. Consistent use of Asthma Control Test (ACT) to measure control (required for MOC)
2. Conduct PCP Asthma check-in visit at least every 4 months for patients with persistent asthma
3. Develop method to track ED/hospitalizations
4. Develop method to track persistent asthma population
5. Integrate care management referral process into office workflow
6. Patients in care management achieve goals stated in care plan
7. Medication Management for People with Asthma (HEDIS Measure) **
8. Asthma Medication Ratio (HEDIS measure)**

**PHN practices participating in our Aetna contract are required to choose HEDIS Measures in Red

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Speakers

Eduardo Fox, MD

Shilpa Patel, MD, MPH

Sandy Chung, MD

No conflicts to disclose:

- No financial or business interest, arrangement or affiliation that could be perceived as a real or apparent conflict of interest in the subject (content) of their presentation.
- No unapproved or investigational use of any drugs, commercial products or devices.

Asthma Care is Changing – Again!

Highlights from the 2020 Updates to the NHLBI Asthma Guidelines

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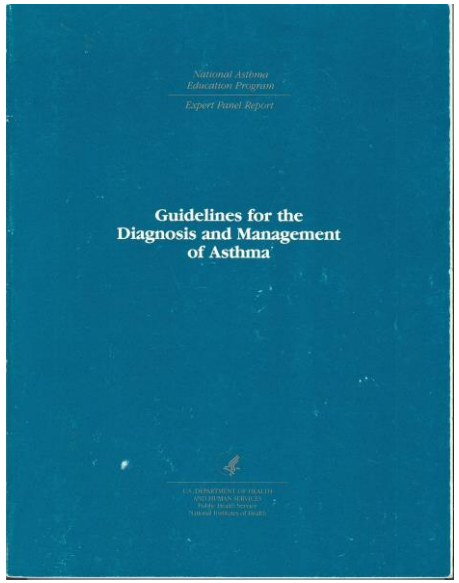
Learning Objectives

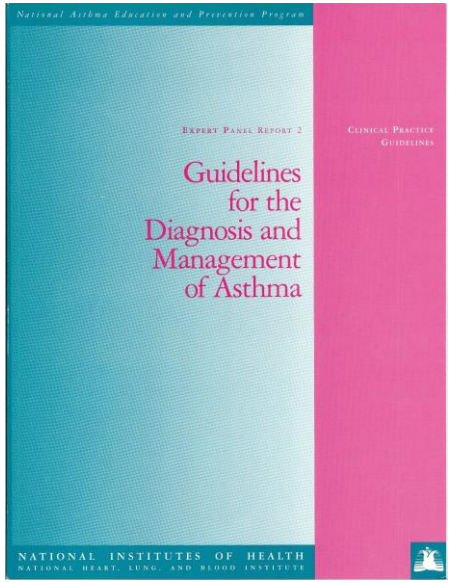
1. Update therapeutic management for children 0 to 4 year old with recurrent wheezing
2. Update therapeutic management of children over 4 year old with persistent asthma
3. Update therapeutic management of children 12 and over with persistent asthma
4. Update management of children with allergy-induced asthma
5. Know how to access practical tools in new NHLBI Asthma Guidelines, including newly formatted Asthma Action Plan

National Institutes of Health

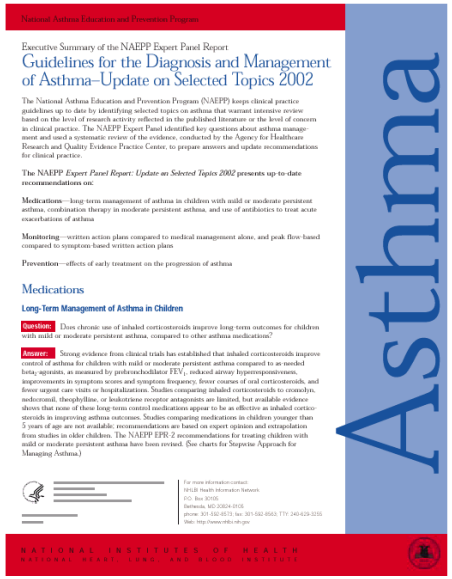
Guidelines for Asthma Care



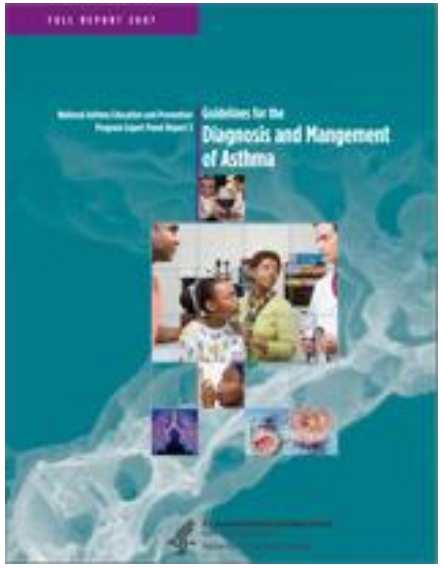
1991



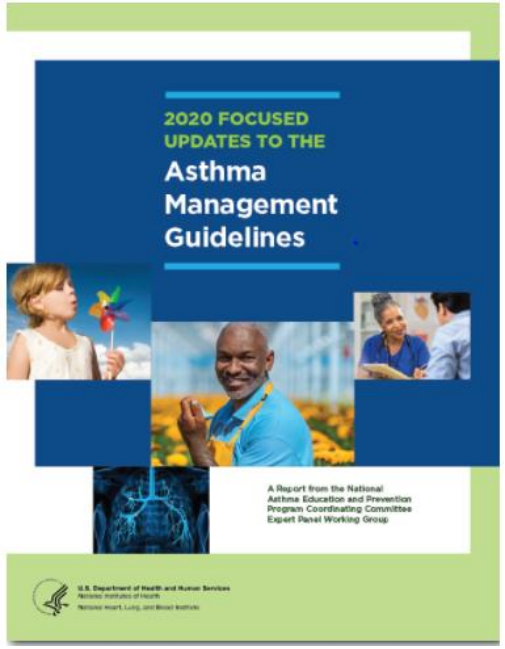
1997



2002



2007



2020

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2020 Focused Updates to the Guidelines

Intermittent Inhaled Corticosteroids (ICS)

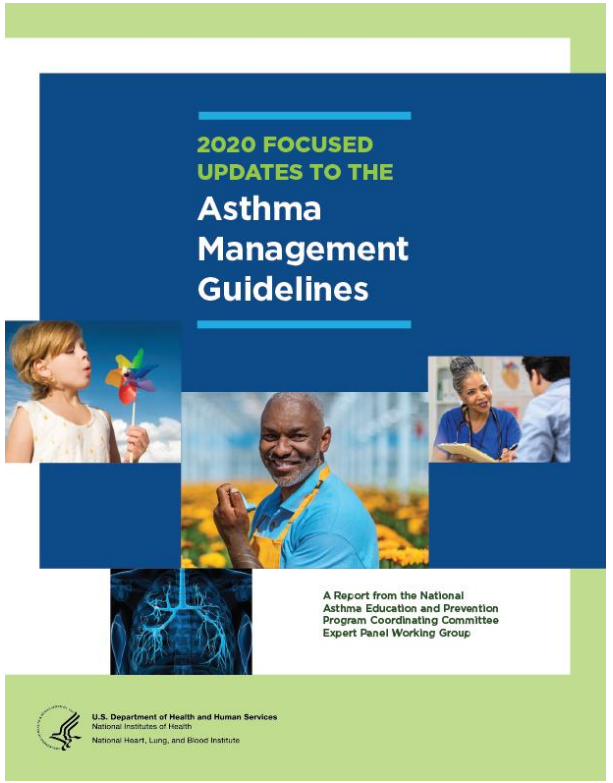
Long-Acting Muscarinic Antagonists (LAMA)

Indoor Allergen Mitigation

Immunotherapy in the Treatment of Allergic Asthma

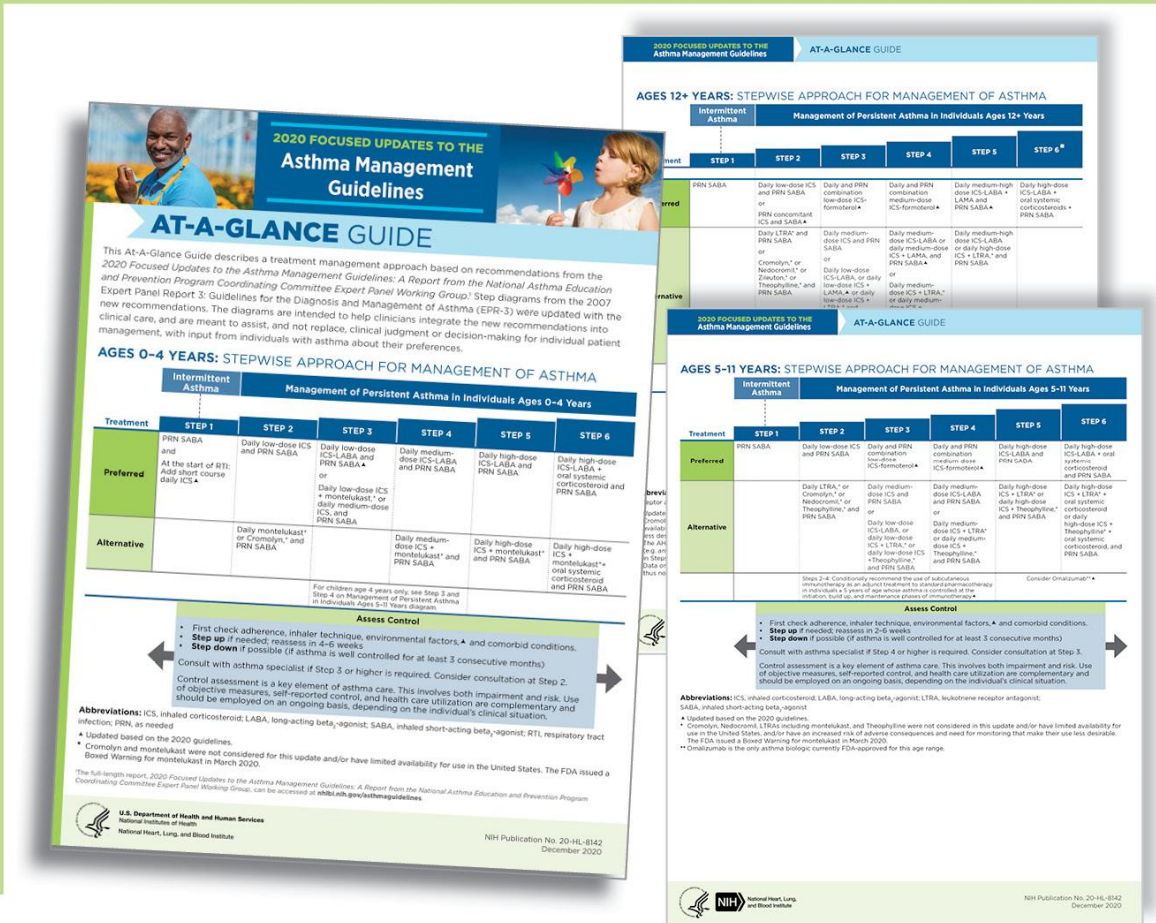
Fractional Exhaled Nitric Oxide Testing

Bronchial Thermoplasty



https://www.nhlbi.nih.gov/health-topics/asthma-management-guidelines-2020-updates

The new asthma guidance is reflected in updated treatment charts based on a stepwise approach for managing asthma.



2020 Focused Updates to the Asthma Management Guidelines
A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group

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Inhaled Corticosteroids – what's new

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Some Quick Definitions

- SABA = short-acting beta agonist (albuterol is our most commonly used SABA)
- LABA = long-acting beta agonist
- ICS = inhaled corticosteroids (fluticasone or Flovent; or beclomethasone-dipropionate or QVAR)
- Combined LABA –ICS = formoterol + budesonide or Symbicort
- LTRA = leukotriene receptor antagonist such as montelukast or Singulair

Inhaled Steroids: Carla

0-4 yo with recurrent wheezing

- 3 yo with mild cold symptoms and wheezing
- PMH:
  - Bronchiolitis at 9 mo
  - 3 wheezing episodes since - ALL associated with URIs
  - Most recent episode occurred 2 months ago when she took an oral steroid course for the first time
- No ED visits or admissions

CURRENT

As-needed SABA for quick-relief therapy

2020 CHANGE

As-needed inhaled SABA for quick-relief with URI onset

+

7–10 day course of daily ICS

TARGET POPULATION

- 0-4 years
- recurrent wheezing
  - ≥3 lifetime wheezing episodes with URI's or ≥ 2 episodes in last 12 months
- no symptoms in between URI's
- not taking daily asthma treatment

BENEFITS

- Reduction in exacerbations requiring systemic corticosteroids

RISK

- Monitor Growth

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Inhaled Steroids: Carla

0-4 yo with recurrent wheezing

- PMH:
  - Bronchiolitis at 9 mo
  - 3 wheezing episodes since - ALL associated with URIs
  - Most recent episode occurred 2 months ago when she took an oral steroid course for the first time
- No ED visits or admissions

Recommendation:

Continue PRN SABA *PLUS 7-10 d course daily ICS*

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Inhaled Steroids: Kevin

4 yrs and older with persistent asthma (mild/mod)

- 9 year old with asthma on fluticasone 44 mcg 2 puffs BID and PRN albuterol presents with cold symptoms and wheezing
- Parents learn from their neighbors that their child's doctor advises them to increase the fluticasone dosing when their child gets sick

CURRENT

As-needed SABA
for quick-relief therapy
+
Daily ICS
+/- short course of high dose ICS for sick plan

2020 UPDATE

As-needed inhaled SABA for quick-relief therapy URI onset
+
Daily ICS

Short course of "high dose ICS bursts" as a sick plan are NOT recommended

TARGET POPULATION

4-11 years with MILD to MODERATE PERSISTENT asthma on daily controller, ICS

Inhaled Steroids: Kevin

4 yrs and older with persistent asthma (mild/mod)

- 9 year old with asthma on fluticasone 44 mcg 2 puffs BID and PRN albuterol presents with cold symptoms and wheezing
- Parents learn from their neighbors that their child's doctor advises them to increase the fluticasone dosing when their child gets sick

Recommendation: PRN SABA ***without*** short course of high dose ICS as a sick plan

Inhaled Steroids: Kevin

4 yrs and older with persistent asthma (mod/severe)

- Kevin's URI and wheezing are improving. He is using albuterol as needed as per his action plan with good effect.
- However, he has needed to use his albuterol about 3 times per week over the last couple of months. He is also waking up coughing about once a week.
- Good adherence with his fluticasone and demonstrates great technique using his inhaler with spacer/mask
- His asthma is not well controlled; he needs a step up in his treatment.

CURRENT

As-needed SABA
for quick-relief therapy
+
Daily ICS
+/- short course of high dose ICS for sick plan

2020 UPDATE

"SMART" therapy
Use a single inhaler with
ICS + LABA(formoterol) = Symbicort
Use this for both DAILY and PRN treatment

TARGET POPULATION

4-11 years MODERATE to SEVERE PERSISTENT asthma on low or medium dose ICS

Inhaled Steroids: Kevin

4 yrs and older with persistent asthma (mod/severe)

- He has needed to use his albuterol about 3 times per week over the last couple of months. He is also waking up coughing about once a week.
- Good adherence with his fluticasone and demonstrates great technique using his inhaler with spacer/mask
- His asthma is not well controlled; he needs a step up in his treatment

Recommendation:
"SMART" Therapy

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Inhaled Steroids: Joey

12yo and older with persistent asthma (mild)

- 14 yo with mild persistent asthma, well controlled. Here for a follow up visit
- Currently using fluticasone 44 mcg 2 puffs BID for maintenance therapy.
- Uses albuterol for quick-relief when his asthma symptoms flare and prior to exercise in cold weather.
- His dad heard about the guidelines update and wonders if there will be any change in his treatment / action plan.
- Usually has more symptoms during winter and required oral steroids last February.

CURRENT

As-needed SABA for quick-relief therapy

+

Daily ICS

2020 UPDATE (2 Options)

1. Continue current treatment

or

2. Intermittent as-needed SABA and ICS used one after the other for worsening asthma. (ie, 2–4 puffs of albuterol followed by 80–250 mcg of beclomethasone equivalent every 4 hours prn)

TARGET POPULATION

12 years and older with MILD PERSISTENT asthma on Step 2 therapy

Inhaled Steroids: Joey

12yo and older with persistent asthma (mild)

- 14 yo with mild persistent asthma, well controlled on fluticasone 44 mcg 2 puffs BID, here for a follow up visit
- Uses albuterol for quick-relief when his asthma symptoms flare and prior to exercise in cold weather.
- Usually has more symptoms during winter and required oral steroids last February.

Recommendation:

1) Continue ***current*** therapy OR

2) intermittent **PRN SABA + ICS Q4 hours**

Inhaled Steroids: Joey

12yos and older with persistent asthma (mod/severe)

- A month later, Joey returns to see you following an ED visit 2 days earlier for an asthma exacerbation.
- He took his second dose of dexamethasone yesterday and is feeling better but still using his albuterol every 4 hrs. You and his mom develop and discuss a plan to address his acute symptoms.
- You also advise that Joey step up his maintenance therapy. You review the guidelines updates with them and make your recommendation.

CURRENT

Increase his ICS dose, change to low-dose ICS/LABA, or add LTRA.

2020 UPDATE

Preferred treatment is a single inhaler with ICS-formoterol ("SMART") used both daily and as needed.

TARGET POPULATION

12 years and older with MODERATE to SEVERE PERSISTENT asthma (on low or medium dose ICS)

Inhaled Steroids: Joey

12 yo and older with persistent asthma (mod/severe)

- A month later, Joey returns to see you following an ED visit 2 days earlier for an asthma exacerbation.
- He took his second dose of dexamethasone yesterday and is feeling better but still using his albuterol every 4 hrs. You and his mom develop and discuss a plan to address his acute symptoms.

Recommendation: **'SMART'** Therapy

"SMART" Therapy: **S**ingle **m**aintenance **a**nd **r**eliever **t**herapy

INDICATIONS	DOSING
• Step 3 (low-dose ICS) and Step 4 (medium-dose ICS) treatment. • Patients poorly controlled on ICS-LABA with SABA as quick relief	• 1–2 puffs once or twice daily for maintenance and 1–2 puffs as needed for asthma symptoms. • Maintenance dosing and frequency depends on age, asthma severity, and ICS dose in the ICS-formoterol preparation

Maximum number of puffs per day (based on 4.5 mcg formoterol/inhalation):

Ages 4-11: 8 puffs (36 mcg formoterol)

Ages 12 years and older: 12 (54 mcg formoterol)

Note: formoterol is the only LABA studied for use in SMART therapy

"SMART" Therapy

Potential benefits:

- Reduced asthma exacerbations, unscheduled medical visits or systemic corticosteroids
- May improve asthma control and quality of life

Potential risks: No difference in documented harms compared to daily ICS, or ICS-LABA, with SABA as quick relief therapy.

Other considerations:

- There may be a lower risk of growth suppression among those taking SMART versus daily higher-dose ICS treatment (4-11 yo).
- Need to consider cost, formulary considerations, or medication intolerance.
- 1-month supply may not last a month if the inhaler is used for reliever therapy in addition to maintenance.

Indoor Allergen Mitigation

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Indoor Allergen Mitigation

Little evidence that mitigation strategies as part of routine asthma care are beneficial for improving asthma outcomes.

If no history or symptoms of allergies to indoor triggers, then no interventions are recommended.

If exposed and allergic (= sensitization or symptoms related to exposure):

- Use multiple mitigation strategies to reduce indoor allergen.
- Using just one strategy often does not improve outcomes.
- Mitigation strategies can include air purifiers, impermeable pillow and mattress covers, HEPA filters, pest management, and water damage remediation.
- Use pillow/mattress covers only as part of a multicomponent intervention.

Indoor Allergen Mitigation (cont.)

Integrated pest management in the home is recommended for individuals with asthma who are allergic and exposed to cockroaches or rodents (e.g., mice).

Need to consider:

- allergen testing
- asthma severity
- potentially small benefit
- expense of mitigation strategies

General Considerations for Implementation of Updates

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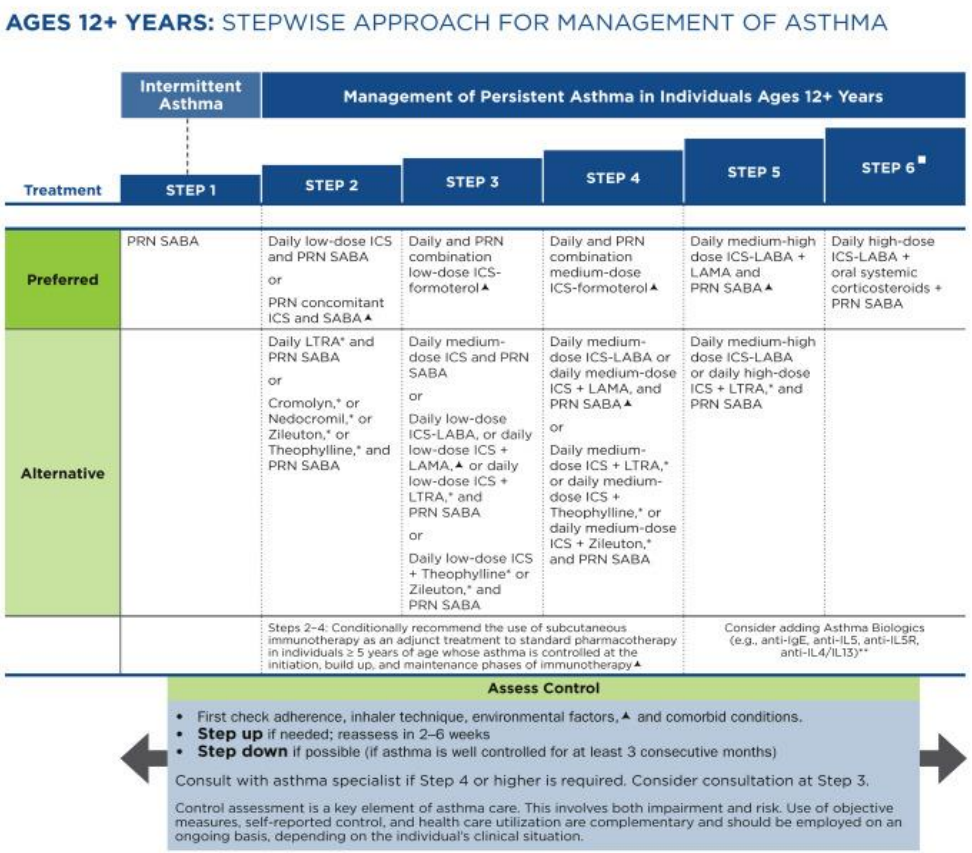
Considerations

- Management:
  - Continue to emphasize step-wise approach to therapy
  - More options and greater flexibility
  - Focused updates to the 2007 guidelines
- Billing and coverage
  - Insurance coverage for new regimens
  - FDA review/formulary
- Changing documentation
  - EMR integration/ templates
  - Changes to asthma action plan
- Gradual implementation

Resources: Please refer to PHN Asthma Toolkit



AGES 12+ YEARS: STEPWISE APPROACH FOR MANAGEMENT OF ASTHMA

Treatment	Intermittent Asthma: STEP 1	Management of Persistent Asthma in Individuals Ages 12+ Years: STEP 2	STEP 3	STEP 4	STEP 5	STEP 6■
Preferred	PRN SABA	Daily low-dose ICS and PRN SABA or PRN concomitant ICS and SABA▲	Daily and PRN combination low-dose ICS-formoterol▲	Daily and PRN combination medium-dose ICS-formoterol▲	Daily medium-high dose ICS-LABA + LAMA and PRN SABA▲	Daily high-dose ICS-LABA + oral systemic corticosteroids + PRN SABA
Alternative		Daily LTRA* and PRN SABA or Cromolyn,* or Nedocromil,* or Zileuton,* or Theophylline,* and PRN SABA	Daily medium-dose ICS and PRN SABA or Daily low-dose ICS-LABA, or daily low-dose ICS + LAMA,▲ or daily low-dose ICS + LTRA,* and PRN SABA or Daily low-dose ICS + Theophylline* or Zileuton,* and PRN SABA	Daily medium-dose ICS-LABA or daily medium-dose ICS + LAMA, and PRN SABA▲ or Daily medium-dose ICS + LTRA,* or daily medium-dose ICS + Theophylline,* or daily medium-dose ICS + Zileuton,* and PRN SABA	Daily medium-high dose ICS-LABA or daily high-dose ICS + LTRA,* and PRN SABA	
		Steps 2–4: Conditionally recommend the use of subcutaneous immunotherapy as an adjunct treatment to standard pharmacotherapy in individuals ≥ 5 years of age whose asthma is controlled at the initiation, build up, and maintenance phases of immunotherapy▲			Consider adding Asthma Biologics (e.g., anti-IgE, anti-IL5, anti-IL5R, anti-IL4/IL13)**	

Assess Control

- First check adherence, inhaler technique, environmental factors,▲ and comorbid conditions.
- **Step up** if needed; reassess in 2–6 weeks
- **Step down** if possible (if asthma is well controlled for at least 3 consecutive months)

Consult with asthma specialist if Step 4 or higher is required. Consider consultation at Step 3.

Control assessment is a key element of asthma care. This involves both impairment and risk. Use of objective measures, self-reported control, and health care utilization are complementary and should be employed on an ongoing basis, depending on the individual's clinical situation.

Abbreviations: ICS, inhaled corticosteroid; LABA, long-acting beta$_2$-agonist; LAMA, long-acting muscarinic antagonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta$_2$-agonist

▲ Updated based on the 2020 guidelines.

* Cromolyn, Nedocromil, LTRAs including Zileuton and montelukast, and Theophylline were not considered for this update, and/or have limited availability for use in the United States, and/or have an increased risk of adverse consequences and need for monitoring that make their use less desirable. The FDA issued a Boxed Warning for montelukast in March 2020.

** The AHRQ systematic reviews that informed this report did not include studies that examined the role of asthma biologics (e.g. anti-IgE, anti-IL5, anti-IL5R, anti-IL4/IL13). Thus, this report does not contain specific recommendations for the use of biologics in asthma in Steps 5 and 6.

■ Data on the use of LAMA therapy in individuals with severe persistent asthma (Step 6) were not included in the AHRQ systematic review and thus no recommendation is made.

December 2020

ASTHMA ACTION PLAN

For: _____ Doctor: _____ Date: _____

Doctor's Phone Number: _____ Hospital/Emergency Department Phone Number: _____

GREEN ZONE

DOING WELL

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than _____
(80 percent or more of my best peak flow)

My best peak flow is: _____

Daily Medications

Medicine	How much to take	When to take it

Before exercise	☐ _____	☐ 2 or ☐ 4 puffs	5 minutes before exercise

YELLOW ZONE

ASTHMA IS GETTING WORSE

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: _____ to _____
(50 to 79 percent of my best peak flow)

1st **Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.**

_____ (quick-relief medicine) _____ Number of puffs **or** ☐ Nebulizer, once

Can repeat every _____ minutes up to maximum of _____ doses

2nd **If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**

☐ Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

☐ Take: _____ (quick-relief medicine) _____ Number of puffs **or** ☐ Nebulizer

☐ Add: _____ (oral steroid) mg per day For _____ (3-10) days

☐ Call the doctor ☐ before/ ☐ within _____ hours after taking the oral steroid.

RED ZONE

MEDICAL ALERT!

- Very short of breath, or
- Quick-relief medicines have not helped,
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than _____
(50 percent of my best peak flow)

Take this medicine:

☐ _____ (quick-relief medicine) _____ Number of puffs **or** ☐ Nebulizer

☐ _____ (oral steroid) mg

Then call your doctor NOW. Go to the hospital or call an ambulance if:

- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS

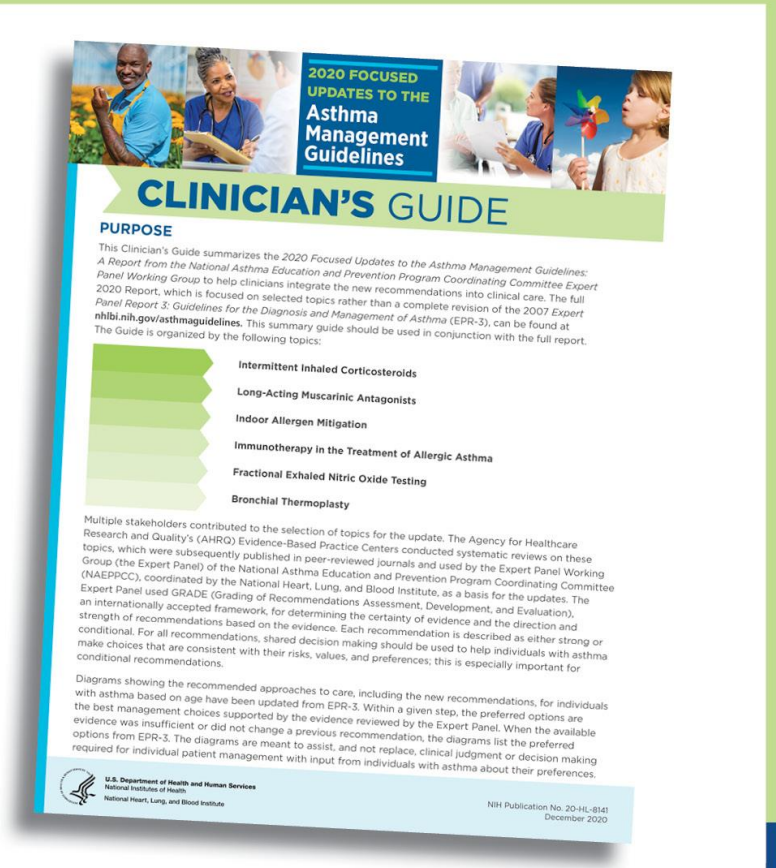
- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

→

- **Take _____ puffs of _____ (quick relief medicine) AND**
- **Go to the hospital or call for an ambulance _____ (phone) NOW!**

See the reverse side for things you can do to avoid your asthma triggers.

The Clinician's Guide summarizes the *2020 Updates to the Asthma Management Guidelines*, with information to help providers integrate the new recommendations into clinical care.



National Heart, Lung, and Blood Institute

2020 Focused Updates to the Asthma Management Guidelines
A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group

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The PHN Asthma Toolbox – current contents

- Link to NHLBI guidelines, toolkit, and patient education materials
- Newly formatted AAP
- Dosing for in-office albuterol MDI use in asthma exacerbations (to replace nebulizer use during COVID)
- Asthma Control Test
- Coding and Billing Tips

IMPACT DC – How to refer for virtual or in-person visits

1. By email: IMPACTDC@childrensnational.org
2. By phone: 202-476-3970
3. Through eCW referral [Impact DC under Provider & Send fax].

- Just need patient info and contact info – IMPACT DC team will do the rest.
- Patients with asthma impairment, missing school days, or poor asthma education should also be referred.
- In-person visit location THEARC in southeast DC

IMMUNOTHERAPY IN THE TREATMENT OF ALLERGIC ASTHMA

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Immunotherapy

Subcutaneous Immunotherapy (SCIT)

Recommended as an adjunct treatment for:

- 5 Years and older
- Mild to moderate allergic asthma (not severe)
- Demonstrated sensitization and symptoms related to exposure to relevant allergen
- No acute asthma symptoms

Sublingual Immunotherapy

The evidence reviewed did not support the use of SLIT specifically for the treatment of allergic asthma.

Long-Acting Muscarinic Antagonists

Long-Acting Muscarinic Antagonists (LAMA)

12 Years and Older with Uncontrolled Persistent Asthma

LAMA: Pharmacologic class of long-acting bronchodilators

Key Points:

- Adding a LABA rather than a LAMA to an ICS is recommended when asthma is not controlled by ICS alone.
- If a LABA cannot be used, adding a LAMA to an ICS is an acceptable alternative (small potential benefit)
- If already on ICS-LABA, adding a LAMA is recommended for many individuals (may improve asthma control and quality of life)small potential benefit).

Potential risks:

- Do not use in those with glaucoma or at risk for urinary retention.
- No more benefit than adding a LABA to ICS controller therapy
- May increase the risk of harm (based on a single real-world study in Blacks)

Asthma Coding

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Goals for Today

- Review the E&M Coding changes
- Work through case examples
- Review why it matters

What are the changes?

E&M CODES ARE NOW CHOSEN BASED ON:

TIME

OR

MEDICAL DECISION MAKING

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TIME RANGE CHANGES

2021 Time Ranges for Office-Based E/M Services

New Patient	2021 Total Time Range	Established Patient	2021 Total Time Range
99202	15-29 mins	**99212**	10-19 mins
99203	30-44 mins	**99213**	20-29 mins
99204	45-59 mins	**99214**	30-39 mins
99205	60-74 mins	**99215**	40-54 mins

Note: 99201 was deleted and 99211 does not have typical time as it will be reported for nurse-only visits or very brief physician visits not meeting the level 2 criteria.

AAP 2021 OFFICE-BASED E/M CHANGES

What is included in TIME?

All must be done on same day

1. Preparing to see the patient (eg, review of tests)

2. Obtaining and/or reviewing separately obtained history

3. Performing a medically appropriate examination and/or evaluation

4. Counseling and educating the patient/family/caregiver

5. Ordering medications, tests, or procedures

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6. Referring and communicating with other health care professionals (when not reported separately)

7. Documenting clinical information in the electronic or other health record

Does NOT include staff time!

8. Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver

9. Care coordination (not reported separately)

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AMA OFFICE EVALUATION AND MANAGEMENT
(E/M) CPT CODE REVISIONS MODULE, 2021

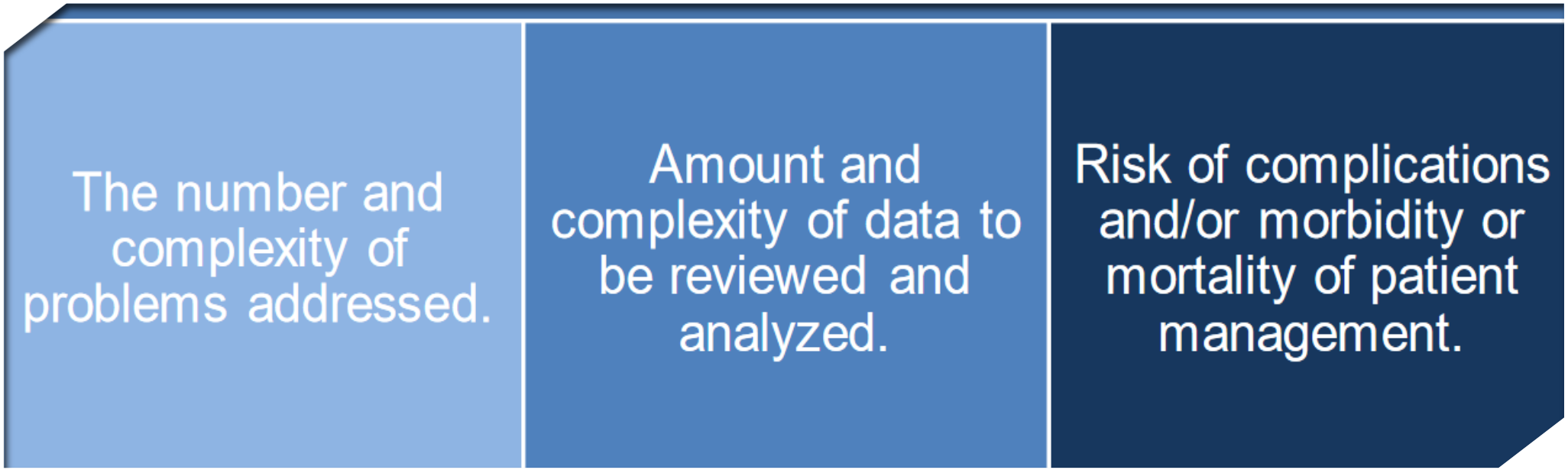
NEW PROLONGED SERVICES CODE - 99417

- Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes

  (List separately in addition to codes **99205, 99215**)

  (Do not report **99417** in conjunction with 99354,99355, 99358, 99359, 99415, 99416)

  (Do not report **99417** for any time unit less than 15 minutes)
- Only reported when your office-based E/M service is reported based on time
- Only reported when you exceed the time spent in 99205 or 99215 (see CPT Threshold Chart)
- Reported "per 15 minutes" beyond the first 99417 (See CPT Prolonged Services chart)



Medical Decision Making

Code	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**
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			
			Category 1: Tests and documents
			• **Any combination of 2 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*
			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 treatment

99204
99214
	Moderate	**Moderate**
		• **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
			Moderate
			(Must meet the requirements of at least 1 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)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				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

99205
99215
	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
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Medical Decision Making: Terms and Definitions

Term	Definition
Minimal problem	A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211).
Self-limited or minor problem	A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.
Stable, chronic illness	A problem with an expected duration of at least a year or until the death of the patient.
Acute, uncomplicated illness or injury	A recent or new short-term problem with low risk of morbidity for which treatment is considered.
Acute, complicated injury	An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Medical Decision Making: Terms and Definitions

Term	Definition
Chronic illness with severe exacerbation, progression, or side effects of treatment	The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.
Acute or chronic illness or injury that poses a threat to life or bodily function	An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment.
Chronic illness with exacerbation, progression, or side effects of treatment	A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.
Undiagnosed new problem with uncertain prognosis	A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.
Acute illness with systemic symptoms	An illness that causes systemic symptoms and has a high risk of morbidity without treatment.

TIPS AND EXAMPLES

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Billing: Carla

3 y.o. with stable intermittent asthma

- Pediatrician's timeline:
  - *8 AM* – **5 minute** review of notes made by the patient's chronic care coordinator since the patient's last visit for management of intermittent asthma
  - *11 AM* – Provider sees patient for a face to face E/M service including history and examination necessary to address stable intermittent asthma (low complexity problem). Provider counsels patient and family on recommendation to continue asthma medications (moderate risk of morbidity to treatment)
  - *11:26 AM* - Provider spends **5 minutes** documenting visit, checking the patient's health plan formulary, ordering medications, and updating patients care plan

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Billing: Carla

3 y.o. with stable intermittent asthma

- 5 minute review of care coordinator's notes since patient's last visit for management of intermittent asthma
- 26 minute face-to-face E/M service
- 5 minutes documentation of visit, placing medication orders, and updating care plan

Total time spent = 36 minutes

Bill with code *99214* based on total time spent on day of visit in lieu of code 99213

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99214 based on time

Table 2

Time Versus Medical Decision-making

Code and Total Time *New patient* (99202–99205) *Established patient* (99212–99215)	Number and Complexity of Problems Addressed at the Encounter	Amount and Complexity of Data to Be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 15–29 min	Minimal	Minimal or none	Minimal
99212 10–19 min			
99203 30–44 min	**Low**	**Limited**	Low
99213 20–29 min			
99204 45–59 min	Moderate	Moderate	**Moderate**
99214 30–39 min			
99205 60–74 min	High	Extensive	High
99215 40–54 min			

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Billing: Joey

14 yo with well controlled, mild persistent asthma

18 minutes E/M Service that included:

- History and examination necessary to address well controlled, mild persistent asthma (low complexity problem)
- Requires independent historian (limited amount and complexity of data)
- Counsels patient and family on recommendation of continuation of asthma medications (moderate risk of morbidity from treatment)
- Review and analysis of score on ACT administered by clinical staff (separately reported and not counted towards MDM)
- Refill of asthma medication (moderate risk of morbidity from treatment

Billing: Joey

14 yo with well controlled, mild persistent asthma

- Bill with code *99213* based on level of MDM supported by number and complexity of problems and amount and/or complexity of data in lieu of code 99212 for total time spent
- Code 96160 is also reported for administration and score of ACT test

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99213 based on MDM

Table 3

Medical Decision-making Versus Time

Code and Total Time *New patient* **(99202–99205)** *Established patient* **(99212–99215)**	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and Complexity of Data to Be Reviewed and Analyzed**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99202 15–29 min	Minimal	Minimal or none	Minimal
99212 10–19 min			
99203 30–44 min	**Low**	**Limited**	Low
99213 20–29 min			
99204 45–59 min	Moderate	Moderate	**Moderate**
99214 30–39 min			
99205 60–74 min	High	Extensive	High
99215 40–54 min			

Cory, a 7 y.o. patient previously diagnosed with asthma, presents with acute exacerbation

- Detailed history, detailed examination performed
- Current guidelines – 99214
- **2021 Guidelines**
- Medical Decision Making
  - Chronic illness with mild exacerbation – 99214
  - Chronic illness severe exacerbation – 99215
  - Recommendation to admit patient, but parents want to wait to "give the breathing treatments a chance" - 99215

Menu of Asthma Measures

1. Consistent use of Asthma Control Test (ACT) to measure control (required for MOC)
2. Conduct PCP Asthma check-in visit at least every 4 months for patients with persistent asthma
3. Develop method to track ED/hospitalizations
4. Develop method to track persistent asthma population
5. Integrate care management referral process into office workflow
6. Patients in care management achieve goals stated in care plan
7. Medication Management for People with Asthma (HEDIS Measure)
8. Asthma Medication Ratio (HEDIS measure)

CODING FOR VALUE BASED CARE CONTRACTS

- Need to have a claim reflecting asthma diagnosis during the measurement year
- Maintain an accurate problem list
- Put reminder flags on patient charts
- More specific codes are better (Mild intermittent asthma with acute exacerbation vs Unspecified asthma)
- Compare your reports on patients with asthma to see who is due for a follow up visit

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Top 10 Tips

Risk Adjustment Coding and Medical Documentation

1 Document every page

Include patient's name and date of service on each page of the medical record.

2 Capture each diagnosis

Five+ diagnosis codes for every visit represents "best practice" documentation.

3 Be specific

Document all diagnosis codes to the highest level of specificity

4 Add assessment and treatment plans

Include assessment and treatment plans for each diagnosis (i.e. Assessment: Improved – Treatment Plan – Discontinue Medication).

5 Ask about past conditions

Reaffirm and document prior chronic conditions reflected in past visit notes during every visit.

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6 Be thorough
For each condition noted, documentation must support that the physician Monitored, Evaluated, Assessed/Addressed, Treated (MEAT).

7 Close gaps in care
Include notes on any areas in need of assessment, evaluation or screening.

8 Sign on the dotted line
Ensure physician signature, credentials, and date are included to authenticate medical record.

9 Use all tools available
Utilize and provide Clinical Documentation Improvement (CDI) alerts from your EMR system.

10 When in doubt, document
The more information – the better – to ensure proper documentation of the medical record.

Initiative Next Steps

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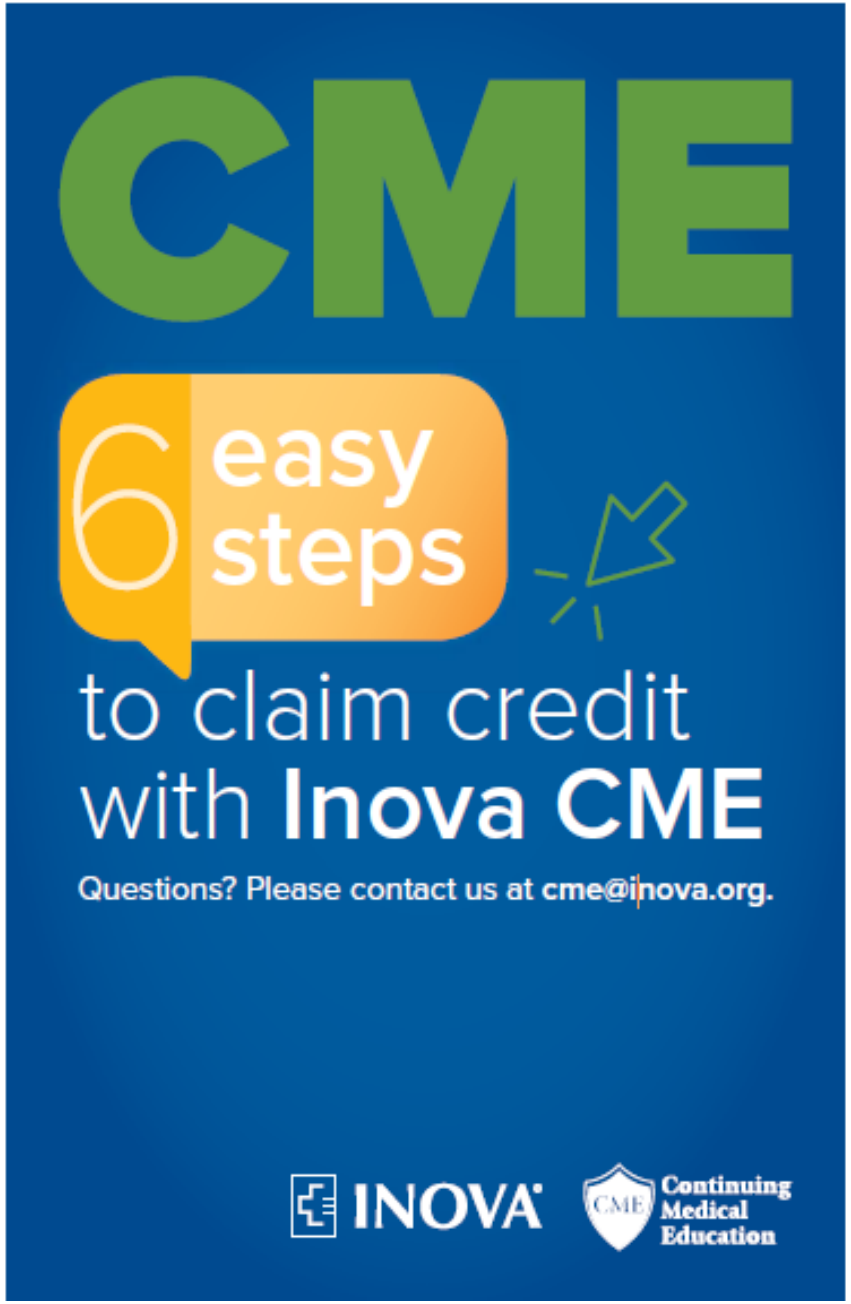
Action Items

1. All practice's must submit **one** response to the data champions survey
   - Data champions will receive an email to select a meeting data in February 2021
2. Review Program Document with practice team
3. Email dtran@childrensnational.org with the email address your practice will use to setup your Glasscubes account
   - Username and password should be distributed to all practice members once account is created by designated team member
4. If you would like to claim MOC Part 4 credit, please complete the "MOC application" in the forms section of Glasscubes

Educational Webinar Schedule

MONTH	TOPIC	REGISTRATION LINK
JANUARY 2021	• Latest Recommendations on Medication Management • New NHLBI Asthma Guidelines • Coding and Billing to Optimize Data Retrieval and Reimbursement	Click here
MARCH 2021	• Patient Education and Asthma Telehealth Visits • When to Refer: The Role of Pulmonologists and Allergists in Asthma Diagnosis and Management	Click here
MAY 2021	• Health Disparities Data for the DMV Region • Social and Environmental Factors Affecting Asthma Outcomes: Tips for Screening and Intervention	Click here
JUNE 2021	• Family Panel • Partnering with Schools • PHN Practice Data: Current Status of our Initiative	Coming soon



Must be claimed within **90** days of event!

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Advancing Asthma Care Webpage

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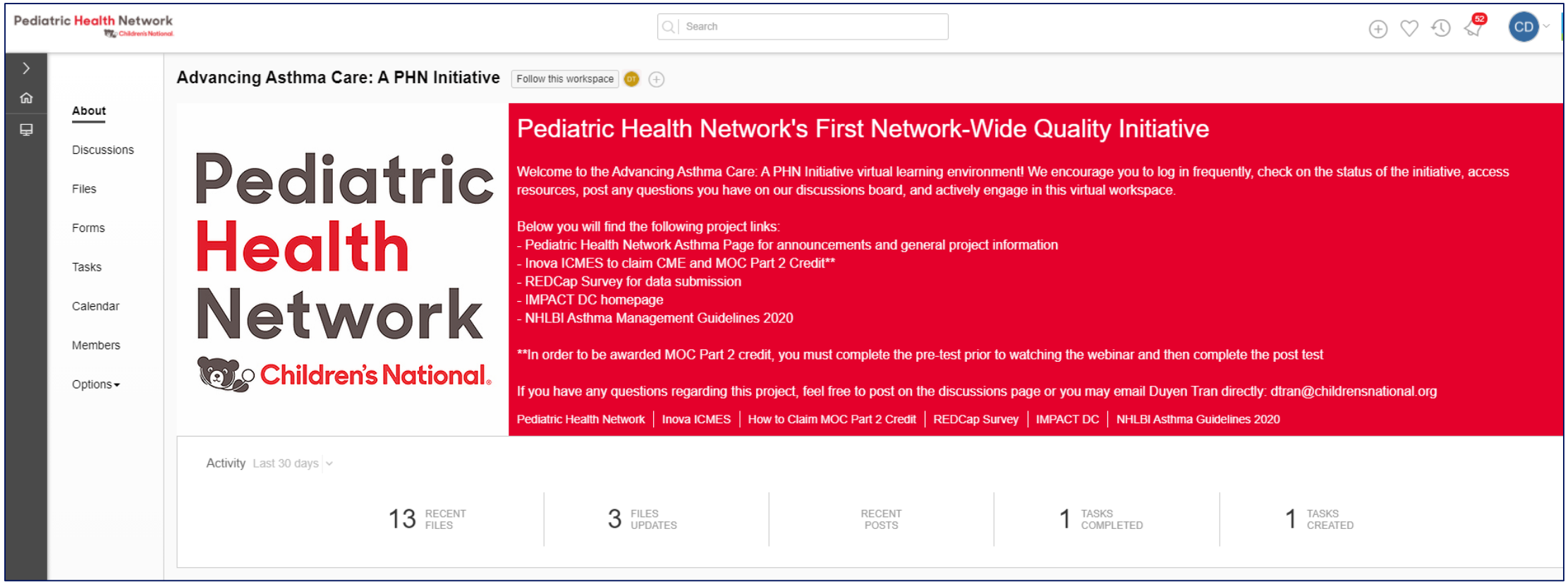
Advancing Asthma Care Virtual Workspace



If you have any questions, please feel free to email PHN@childrensnational.org

All materials from this webinar will be posted on Glasscubes and the PHN webpage