Children's National
Health Network℠
Part of the Children's National Health System

Value Based Coding- Turning Knowledge to Payment!

20th CNHN Pediatric Practice Management Seminar

Wednesday December 6, 2017 11 AM

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Faculty Disclosure

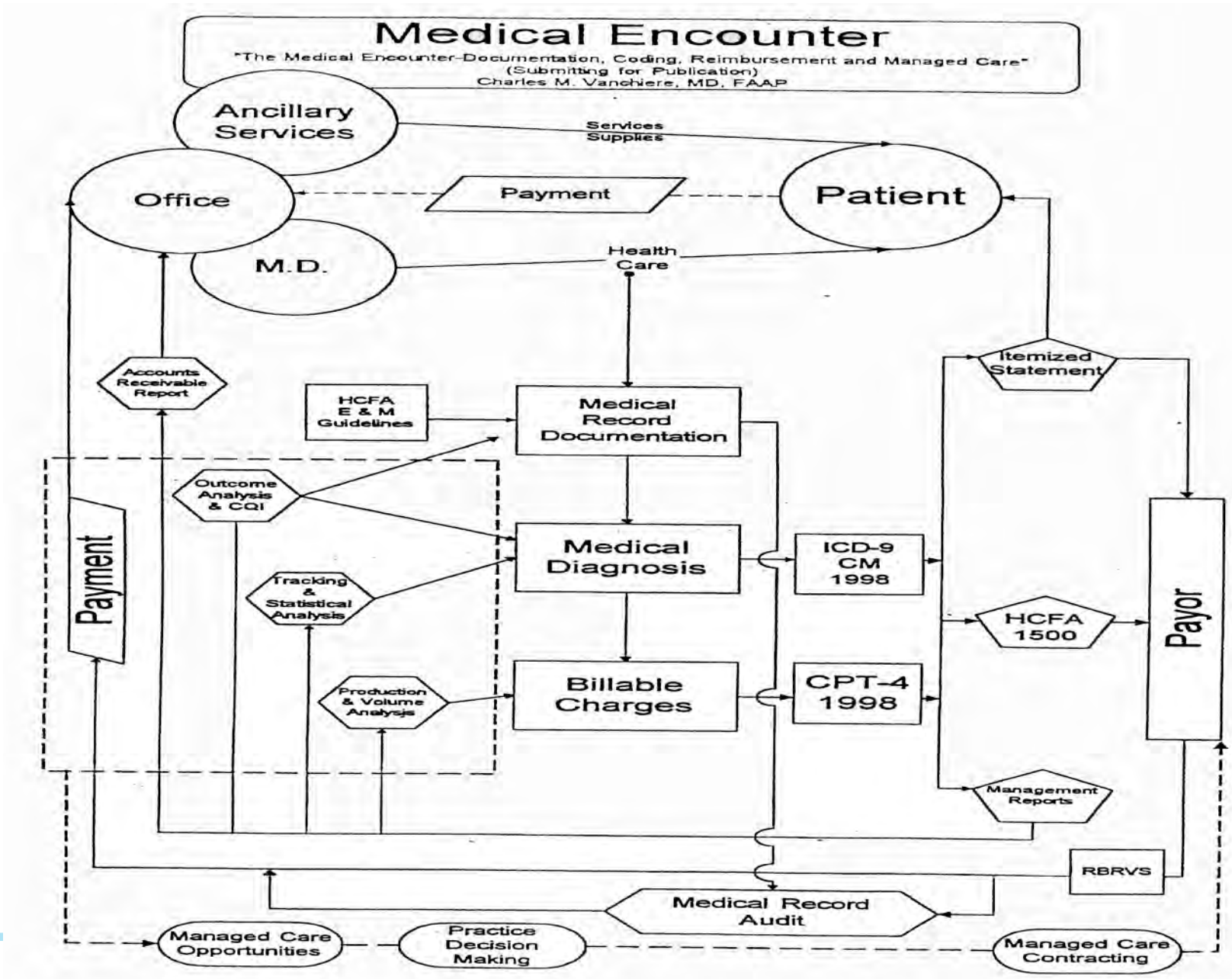
Faculty Disclosure Information

In the past 12 months, we have no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in this CME activity.

I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

Learning Objectives

- Based on this presentation, changes you may wish to make in practice:
  - Beginning 1 Jan.- Use the key coding updates for 2018
  - Apply new knowledge about coding and payment to further your success in Value based payment programs
  - Learn how you can consider new care models built on concepts of population health and team based care


Medical Encounter
"The Medical Encounter-Documentation, Coding, Reimbursement and Managed Care"
(Submitting for Publication)
Charles M. Vanchiere, MD, FAAP
Ancillary Services
Services Supplies
Office
Payment
Patient
M.D.
Health Care
Accounts Receivable Report
HCFA E & M Guidelines
Medical Record Documentation
Itemized Statement
Outcome Analysis & CQI
Payment
Medical Diagnosis
ICD-9 CM 1998
Tracking & Statistical Analysis
HCFA 1500
Payor
Production & Volume Analysis
Billable Charges
CPT-4 1998
Management Reports
RBRVS
Medical Record Audit
Managed Care Opportunities
Practice Decision Making
Managed Care Contracting

Terminology for "Getting Paid"

Reporting:

- the "billing" of CPT codes to a payer for services rendered so they can be paid or tracked (entered into a database)

Licensure:

- a state entity allowing the provider to perform a service under a "scope of practice" law, act, or regulation

Credentialing:

- certification by a public or private payer defining the services for which the provider will be paid

Current Procedural Terminology (CPT)

- Copyrighted publication by the AMA
- Used as the standard Medicare code set since 1990's
- Tell payers **what service** was performed by a physician on a given patient on a given date
- Provides common definitions for physician work based on
  - Nature and amount of work
  - Place and type of service
  - Patient's health and age (in some cases)

CPT Code Categories

Category I:

- Most commonly used codes for billing for patients services- numeric

Category II:

- Performance improvement or tracking codes pay for performance (P4P) measures
- Alphanumeric

Category III:

- New procedures and technology
- Can be used for payment, alphanumeric

ICD-10-CM

- Published by the World Health Organization for epidemiological tracking of illness and injury
- The clinical modification in the US is controlled by the 'cooperating parties'
  - CMS
  - National Center for Health Statistics/CDC
  - American Hospital Association
  - American Health Information Management Association
- Tells Payers about the **Medical Necessity** of services-the **"WHY"**

Payment- The Medicare Physician Fee Schedule Resource Based Relative Value System (RBRVS)

- Is updated each year by CMS- in October -November Federal Register – "Final Rule"
- Is used by the majority of private and public payers (CMS by Year)
- Most CPT codes have a relative value unit - "RVU"
- Each year an updated conversion factor is published- 2015 Payment- rvu x cf

RBRVS Explained

- 2018 -conversion factor = $35.99
- Payment Example-

99213- office visit

RVU = 2.06

CF= $35.99

- So Fee= 2.06 x $35.99 = $74.14

The Revenue Cycle (Getting Paid)

- Provide the services
- Find the correct billing codes
- Assign your fee to each service billed
- Report (Bill) the claim
- Receive your EOB (explanation of benefit) with payment
- Review EOB, inform your coding practice, and appeal denials

(AND NEW)

Participate and succeed in Pay for Value programs

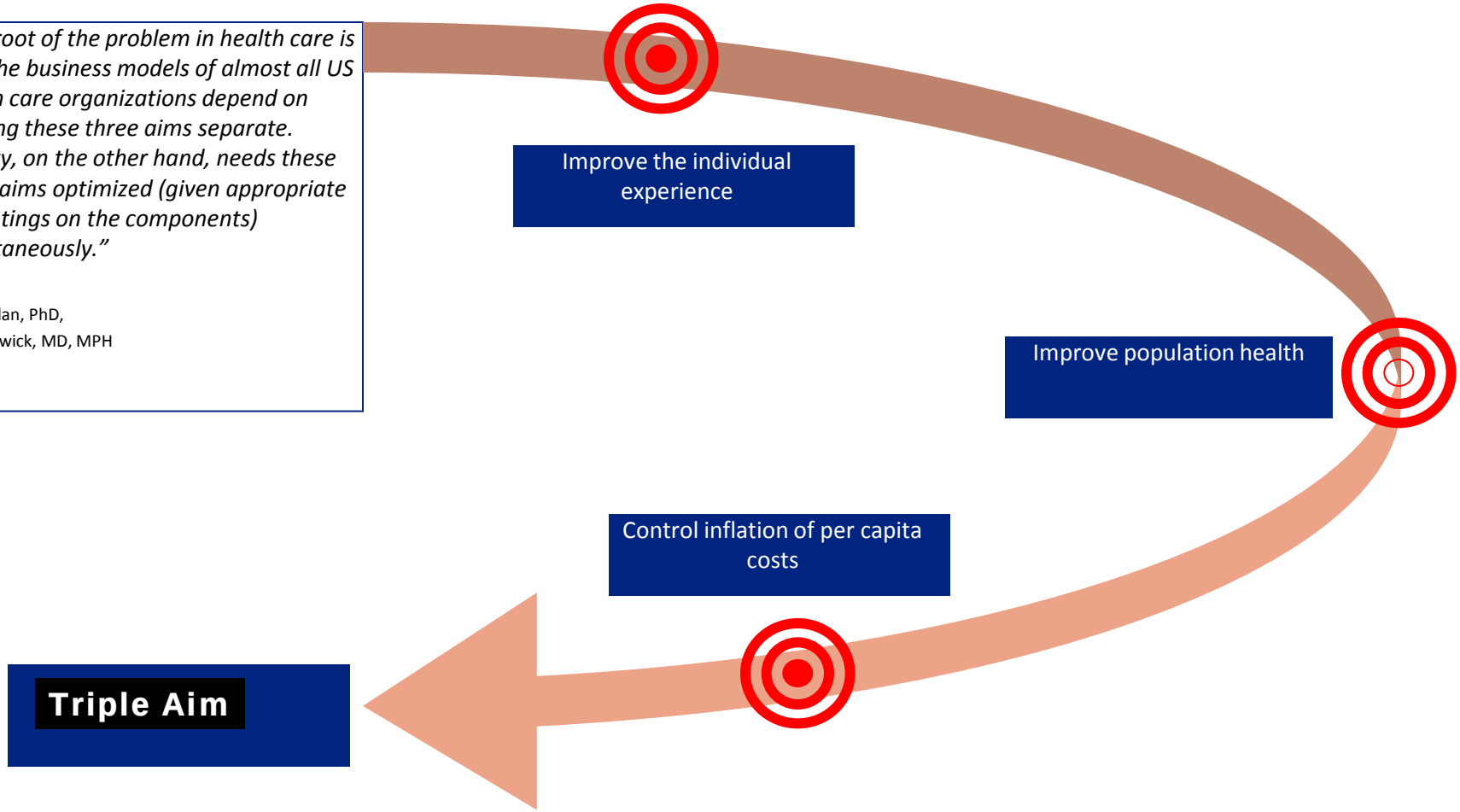
Why Code Correctly? The list Grows!!

- That's how you get paid for clinical activity(service-code-claim-$)
- There is compliance risk if you don't- fraud, waste, abuse
- "Narrow" or Tiered Payer Networks will have fewer providers overall, but more "higher value" providers
- *There is a rapidly evolving alternative payment landscape- Value Based Payment- often additive to your fee schedule (P4P)*

Why We Do What We Do? Achieving the "The Triple Aim"!

"The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these three aims separate. Society, on the other hand, needs these three aims optimized (given appropriate weightings on the components) simultaneously."

Tom Nolan, PhD,
Don Berwick, MD, MPH



"The Triple Aim: Care, Health, And Cost," *Health Affairs*, 27, no.3 (2008): 759-769. Donald M. Berwick, Thomas W. Nolan and John Whittington,

A New Quality- Through the Lens of the Triple Aim

- Ability to reduce variation in outcomes including cost
- Ability to provide *access* allowing "right care, right time, and right place"- afterhours and walk-in (patient centric)
- Ability and performance in closing "Care Gaps"- claim analytics- look at evidenced based care that has not been delivered
- Member Experience- patient activation, shared decision making, and navigation

The New Lexicon – of Health Care

- The Triple Aim
- Accountable Care
- The Value Equation for Health Care
- Value Based Contracting
- Value based insurance product design
- The New Quality
- Population Health
- Care Opportunities
- Variation
- Transparency
- Episodes of Care
- Patient Centered Medical Home
- Health Home for “Superutilizers”
- Narrow Networks

Coding and Value Based Payment

- Bundled Payments- are composed of costs defined by CPT and ICD codes
- Quality metrics- most defined by ICD and CPT codes billed
- Risk adjustment for cost of your patient is based on ICD coding (medical complexity – my patients are sicker)
- Population health- stratification and care gaps defined by risk (coding , utilization, EBM)

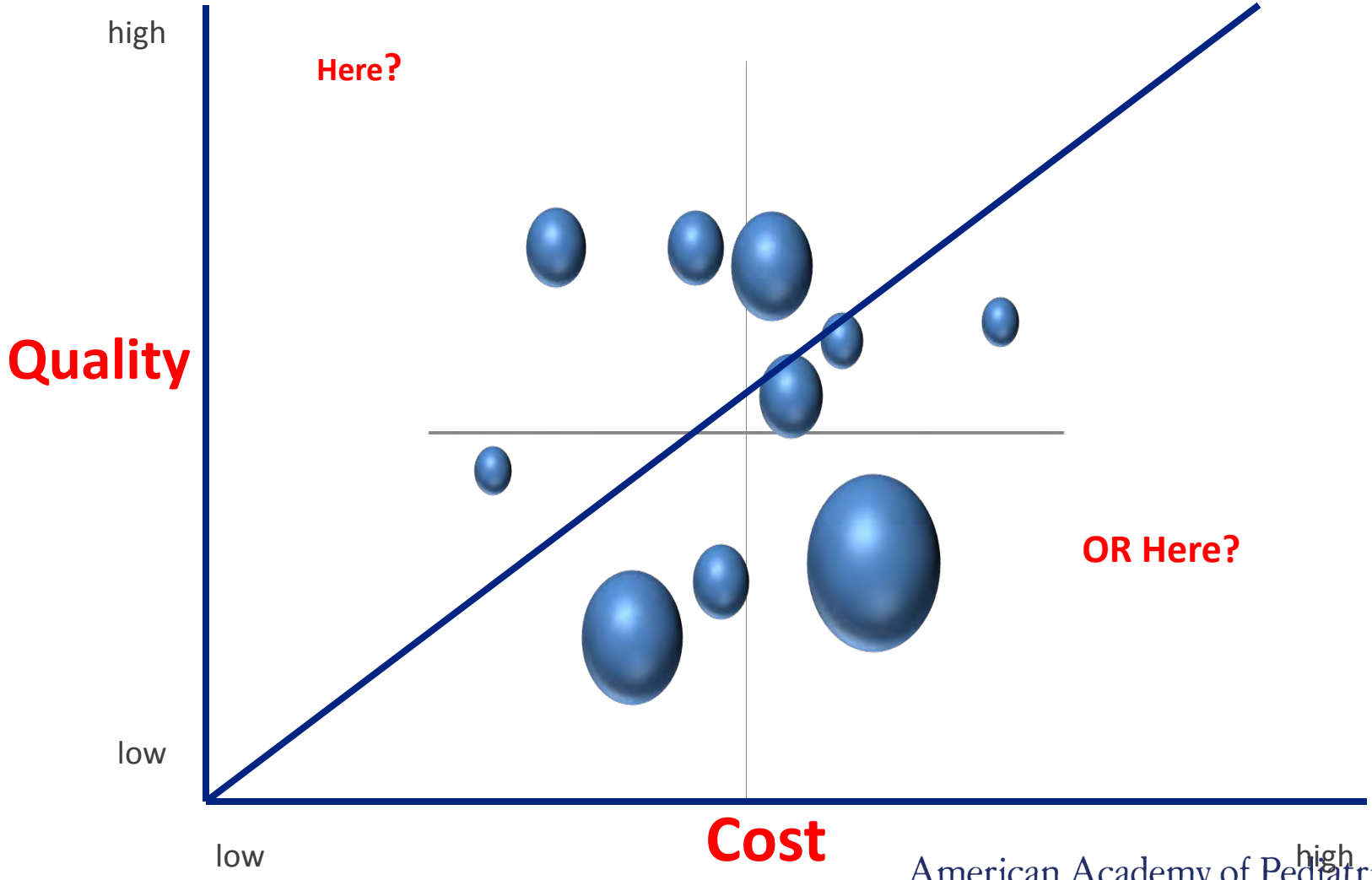
Creating Value in Your Practice

- The Triple Aim - Improving –
  - health care (delivery- eg PCMH)
  - quality of care (outcomes- eg NCQA Measures)
  - the cost of care (right care ,right time, and right place)

- **Creating Value** **Value = Quality / Cost**

- **Payment follows Value**

Tiering- A Triple Aim "Valuegram"



Population Health is Key

- **Once you see your population, you will see the needs and design a better care model-**

1. **"See" your population- data analysis (claims, HRA, clinical)- risk stratified by risk or medical complexity (well, some risk, high risk)**

2. **"See" the needs of your population – "care opportunities"**

    1. **All get Bright Futures (well care, screening, vaccines)**
    2. **Those with Risk get more intense levels of care- care coordination/care management, transitional care**

Population Health is Key

- **Once you see your population, you will see the needs and design a better care model- the 3 "Rights"**

- **Right care- evidenced based/informed/clinical guidelines –**
  - **Bright Futures**
  - **CDC- ACIP Vaccine Schedule**

1. **Right place- in the Medical Home/Office- ACCESS**

2. **Right time – preventive approach- proactive vs reactive care**

Population Health is Key

- **Once you see your population, you will see the needs and design a better care model- the " right care , right place, right time" model**

1. *Your Three Populations-*
   - *They come for all care- and they love you (highly engaged)*
   - *They come for acute care if convenient- they like you- mild-mod.engagement)*
   - *They don't come to your office- use ER. retail./urgent care*

2. Develop Models- include both "outreach" and "in-reach" to close care gaps and provide access to evidenced based pediatrics

3. The Value ($)-
   1. Close care gaps = High Quality (HEDIS/EPSDT)
   2. Right care , place time = Cost savings (share savings)

New Care Models that Improve the Care

- **Integrated care models- develop the "integrated care plan" define medical behavioral and social needs in your population , and deliver on the care and the social solutions**
  - barriers to both quality and cost savings (value) are rooted in behavioral conditions – depression, schizophrenia, bipolar, substance use- must address BEFORE medical needs are met
  - or social determinants – food, shelter, and transportation come before medical care
- **Patient "engagement or activation"**
  1. Measure "engagement" in those with risk or non compliance- tools exist – the new science of compliance
  2. Brings need for Team Care – high touch, collaborative, family centered

Defining Team Based Care Attributes

- Care allows pediatricians to connect with their patients on key clinical issues and provide ***comprehensive, continuous, coordinated care by involving more of the practice staff in patient care as appropriate to their training and capabilities***. Team-based care can also increase a practice's *efficiency and productivity*.
- Care that engages a ***greater number of staff in patient care*** and affords physicians, as the leader of a practice team, additional time to ***listen, think deeply, and develop relationships*** with patients and their families.
- Care that is highly informed- Team members ***are aware of the health history, status, and unique needs of the patient and family***, and are assigned different responsibilities, which together are designed to result in continuous, comprehensive, coordinated care *during and between visits*. Team members feel engaged in their key role of caring for the patient. **THE HUDDLE**

CSHCN –Children with Special Health Care Needs

- 13% of the pediatric population comprises children who meet the Maternal Child Health Bureau definition of special health care needs.

- ***CSHCN (13%) account for 70% of pediatric health care expenditures***.

- Children with Medical Complexity, a subset of this population, are characterized by high service need, medical conditions associated with medical complexity, functional limitations, and high health care use.

Sadof et al, Clinical Pediatrics 1014; 1-5.

Newer Payment Models – Evolving Risk

- **Enhanced Fee for Service**
  - Typically higher rates than “non” PCMH
  - Payment policy (afterhours care, care plan oversight)
  - Evolution to risk – capitation
- **Prospective Payments- funding infrastructure**
  - Care coordination
  - EHR
  - NCQA certification costs
  - Evolution to risk based on outcomes
- **Retrospective Payments- For Performance or Value (new)**
  - Quality Indicators
  - Patient experience
  - Evolution to risk based on a Gain Share

PCMH Reimbursement

Retrospective Payments: Pay for Performance or Value

- Payment in addition to the Fee schedule
- Based on “performance” on certain agreed upon measures
- Program designed by payer(s)
- Comes as an amendment or attachment to the payer contract
- May involve a continuum of risk

Pay for Performance: Evolution Newer Models of Accountable Care

- Gain Sharing – (shared savings)a method for physicians and other providers to share in a defined way in savings a program generates for the population

Gain share may be determined by –

- Improvements compared to a past year(s) in chosen utilization metrics- ER, Inpatient
- Improvements in Total Cost of Care (Medical Loss Ratios - MLR)
- Meeting Quality Targets – the "Gate"

Concept of Financial Risk

- **Upside Risk** - you win- chance of getting a payment if performance targets are met or exceeded

- **Downside Risk** - you may not get a payment if targets are not met (even if you have resource costs in the effort), or in certain models you may lose payment by not hitting targets

- *Programs with downside risk typically have higher potential gains

Pay for Performance or Value-Quality Measures

- Quality Indicators
  - Generally based on national guidelines and evidenced based measures
  - NCQA, NQF, Joint Commission (JCAHO), CMS develop measures
  - Can be reported on billing forms- CPT Category I and Category II codes , ICD codes, other (pharmacy)
  - Measured from claims (administrative), or chart review , or both (hybrid),
  - Can relate to a process or to an outcome
  - Payer will define the measures, the reporting, the targets, and the payments in the contract

HEDIS Basics

- HEDIS = Healthcare Effectiveness Data and Information Set.
- Developed by the National Committee for Quality Assurance (NCQA) in 1993
- 90% of all health plans use HEDIS to measure performance, care, and service.
- HEDIS consists of 81 measures over 5 domains: Effectiveness of Care, Access/Availability, Experience of Care, Utilization & Relative Resource Use, & Health Plan Descriptive Information.

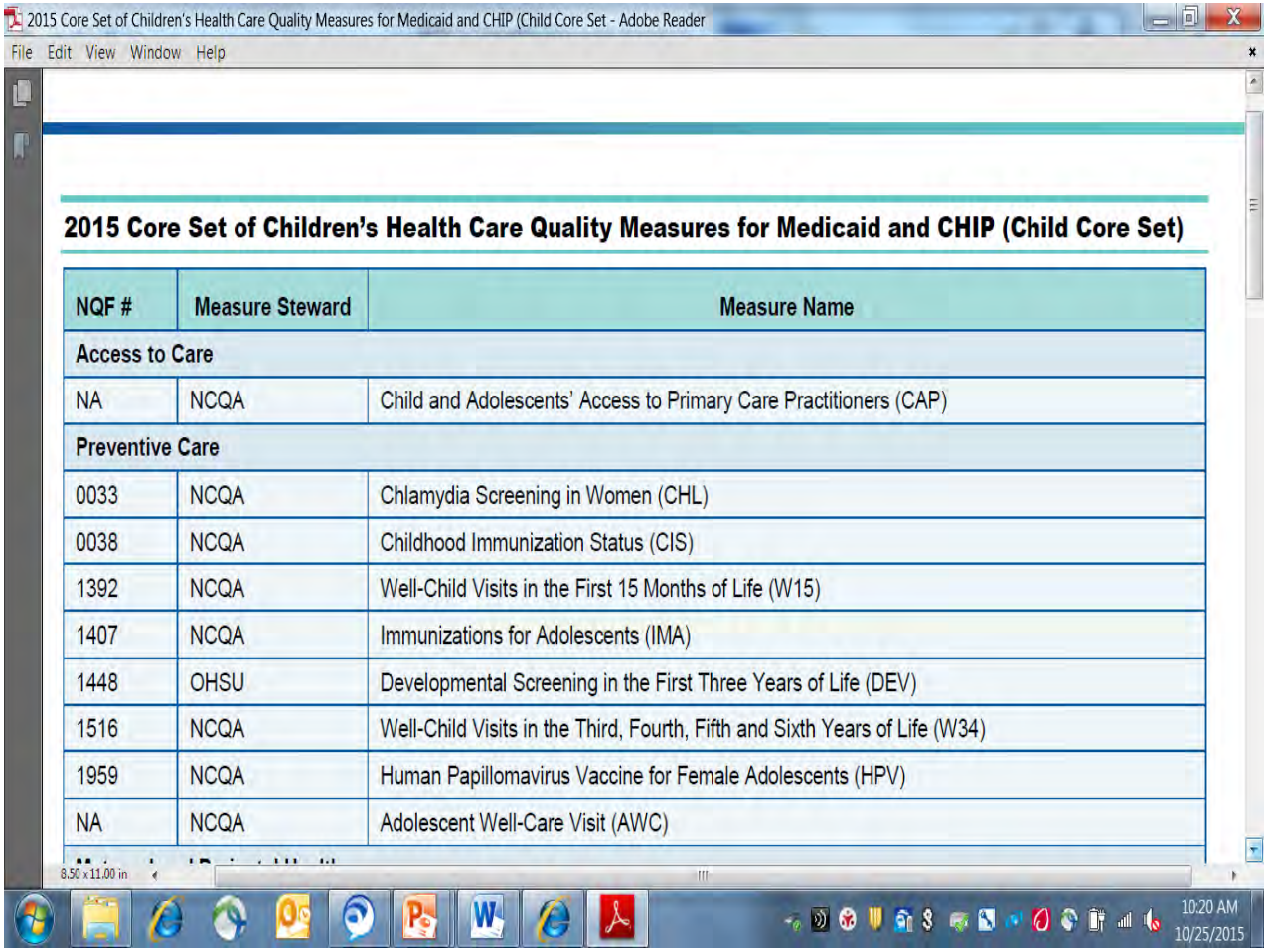
NCQA HEDIS Quality Measures

- Measure the per cent of patients who have had or not had a given health intervention
- Measures have a denominator of the eligible patient population
- Measures have a numerator of the patients who have had the intervention

HEDIS 101

- Data for HEDIS is collected through surveys (CAHPS), medical chart reviews (hybrid metrics), and claims data (administrative metrics).
- HEDIS is one component of NCQA's accreditation process.
- HEDIS measures are updated on an annual basis by NCQA to reflect the most current clinical practice guidelines/evidence based healthcare practices.

CHIP – Core Set



NQF #	Measure Steward	Measure Name
Access to Care		
NA	NCQA	Child and Adolescents' Access to Primary Care Practitioners (CAP)
Preventive Care		
0033	NCQA	Chlamydia Screening in Women (CHL)
0038	NCQA	Childhood Immunization Status (CIS)
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15)
1407	NCQA	Immunizations for Adolescents (IMA)
1448	OHSU	Developmental Screening in the First Three Years of Life (DEV)
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV)
NA	NCQA	Adolescent Well-Care Visit (AWC)

NCQA Quality Measures

1. Appropriate Testing for Children With Pharyngitis (CWP) Ages 2-18 years

- Diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode
- *Commercial, Medicaid (Admin.)*

2. Appropriate Treatment for Children With Upper Respiratory Infection (URI) Ages 3 months–18 years

- Given a diagnosis of URI and were NOT dispensed an antibiotic prescription.
- *Commercial, Medicaid*

Pediatric Well Care Visits

Preventive service E&M

- **Well Care Visits in the First 15 months of Life (W15)**
- **Well Care Visits in the 3rd, 4th, 5th and 6th years of Life (W34)**
- **Adolescent Well Care (AWC)***

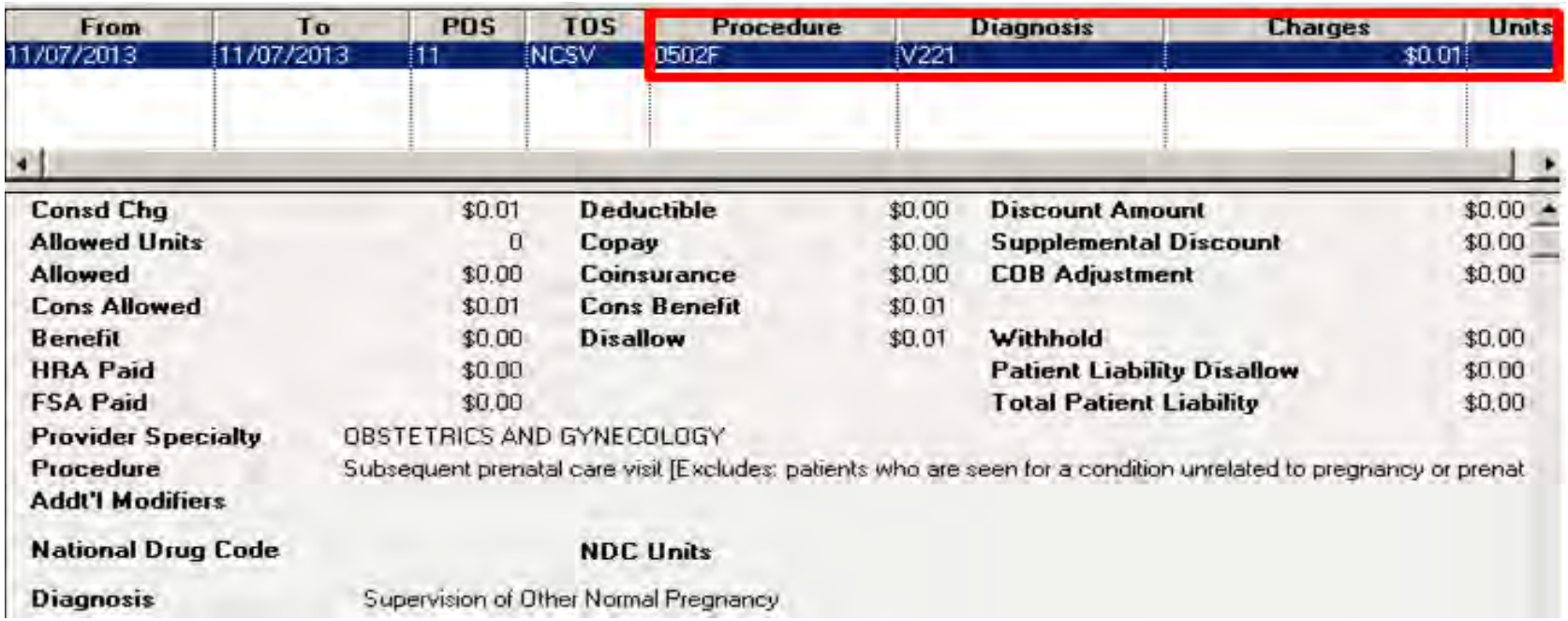
- **Exploit EHR documentation prompts & coding for well care coordinated compliance**
  - BMI percentile, physical activity and nutritional counseling (WCC)
  - Completed, timely UTD immunization documentation (CIS/HPV/IMA)
  - Lead screening (LSC) - document date and result if in history+**(ACC contract)**
  - Chlamydia Screening (CHL) for sexually active 16-24 yo females

Important Points to Remember :

- Utilize age appropriate preventive service/health check CPT and ICD 10 codes
- Include age appropriate documentation supported ICD 10 codes for BMI and activity/nutrition counseling code

REPORTING CPT CAT 2 CODES

Codes Minimize record reviews for Hybrid Measures



From	To	POS	TOS	Procedure	Diagnosis	Charges	Units
11/07/2013	11/07/2013	11	NCSV	0502F	V221	$0.01	

Consd Chg	$0.01	Deductible	$0.00	Discount Amount	$0.00
Allowed Units	0	Copay	$0.00	Supplemental Discount	$0.00
Allowed	$0.00	Coinsurance	$0.00	COB Adjustment	$0.00
Cons Allowed	$0.01	Cons Benefit	$0.01		
Benefit	$0.00	Disallow	$0.01	Withhold	$0.00
HRA Paid	$0.00			Patient Liability Disallow	$0.00
FSA Paid	$0.00			Total Patient Liability	$0.00

Provider Specialty: OBSTETRICS AND GYNECOLOGY
Procedure: Subsequent prenatal care visit [Excludes: patients who are seen for a condition unrelated to pregnancy or prenat
Addt'l Modifiers:
National Drug Code: NDC Units:
Diagnosis: Supervision of Other Normal Pregnancy

HEDIS LINGO

- **HEDIS Care Opportunity = a "GAP" in Care**

A HEDIS Care Opportunity means that there is an outstanding service for a patient, that once completed will result in member compliance for a particular HEDIS measure.

- **How are HEDIS Care Opportunities identified?**

Health Plan identifies Care Opportunities through claims data following the HEDIS specifications for each measure. EHR's can also identify Care Opportunities based on billings, age, etc –population health integration modules

- **How are HEDIS Care Opportunities closed?**

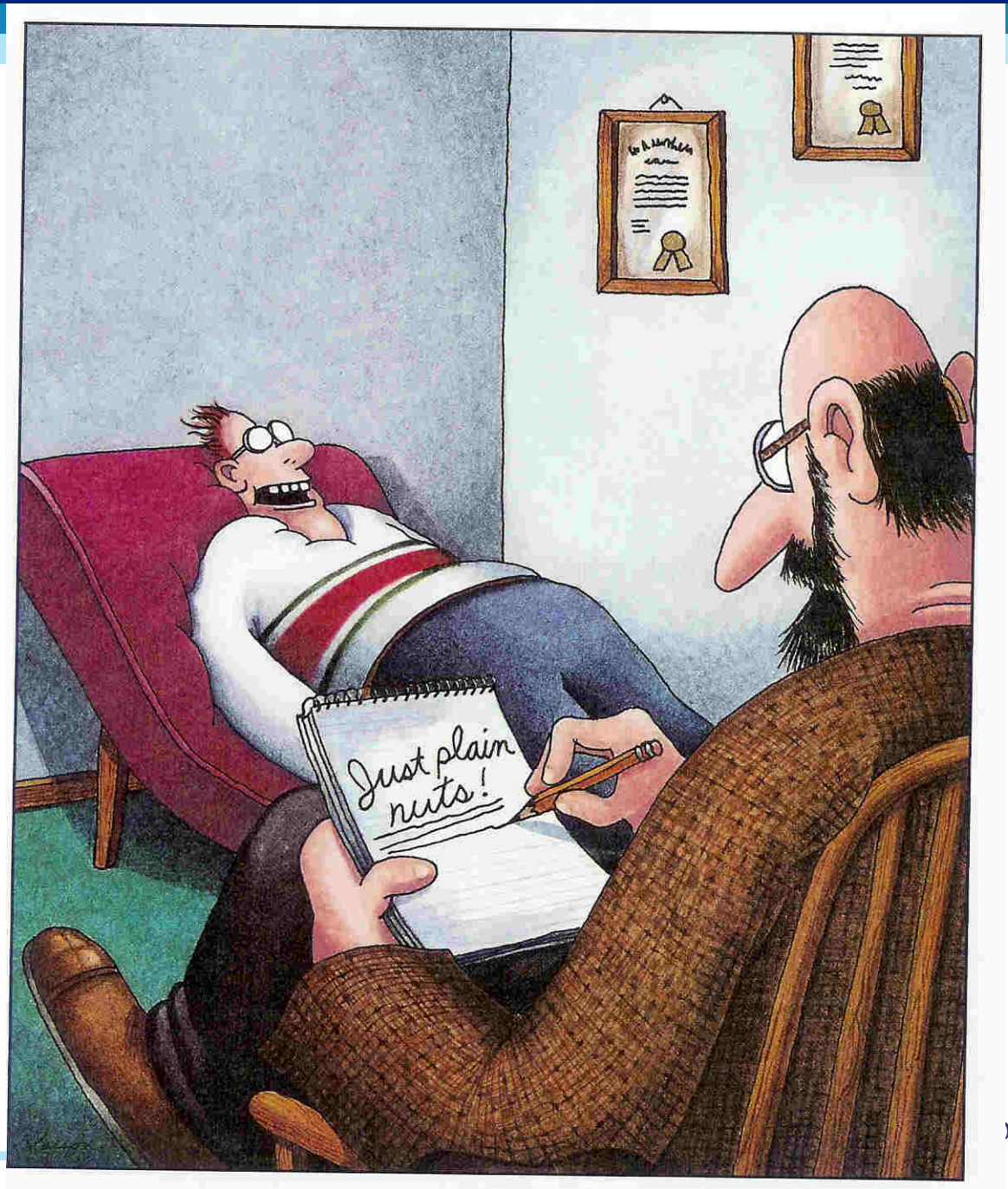
Care Opportunities are closed by completing the required service(s) for the identified members in the specified timeframe and submitting the appropriate codes for the service(s) provided.

•.

New CPT for 2018

- Published in late September (new vaccine can be July or Jan on AMA website)
- Implementation under HIPAA is 1 Jan 2018

** Payers first see new codes and edits as above- new policy and pricing should be in effect by 1 January but check websites and contact payers for any high volume/revenue code changes


Just plain nuts!

Supporting Behavioral health Integration

- Behavioral Care integration with Physical Health
- Supporting evolving care models with 4 new CPT codes for psychiatric collaborative care and general behavioral care management.
- Evidence- better Adult care, higher quality and cost outcomes
- May be more defined than pediatric models
- Medicaid and Private Payers deciding coverage now- CMS covers both for Medicare

PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT (COCM)

- Three codes for TEAM based integrated care
  - 99492
  - 99493
  - 99494
- Reflects a New BH integration Care model
- Very Specific Requirements
- CMS covers- move from G codes to CPT 2018

PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT- REQUIREMENTS

- Services are provided under the direction of a treating physician or other qualified health care professional (QHP)
- Patient has a diagnosed psychiatric disorder that requires a behavioral health care assessment and establishing, implementing, revising, or monitoring a care plan; and provision of brief interventions
- Reported by the treating physician or other QHP

From CPT - "Other Qualified Health Care Professional (QHP)"

CPT now defines as-

A physician or other qualified health care professional is an individual –

– who by education, training, licensure/regulation, and facility privileging (when applicable), performs a professional service within his/her scope of practice

– independently reports a professional service.

– ***These professionals are distinct from 'clinical staff.***

*2012 *CPT Professional Edition* manual.

PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT- REQUIREMENTS

- Include the services of the treating physician or other QHP consultant who has contracted directly with the treating physician or other QHP, to provide consultation.
- Patients directed to the behavioral health care manager typically have newly diagnosed conditions, may need help in engaging in treatment, have not responded to standard care delivered in a non psychiatric setting, or…..
- Require further assessment and engagement, prior to consideration of referral to a psychiatric care setting.

Defining the Model in CPT
The episode of care

- Begins when the patient is directed by the treating physician or other QHP to the behavioral health care manager
- Ends with attainment of targeted treatment goals, resulting in the discontinuation of care management services , OR failure to attain targeted treatment goals culminating in referral to a psychiatric care provider for ongoing treatment; or
- Lack of continued engagement with no psychiatric collaborative care management services provided over a consecutive six month calendar

Defining the Model in CPT
The provider Definitions

Health care professionals - the treating physician or other QHP who directs the behavioral health care manager and continues to oversee the patient's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.

- Evaluation and management (E/M) and other services may be reported separately by the same physician or other QHP during the same calendar month.

Defining the Model in CPT
The provider Definitions

Behavioral health care manager refers to clinical staff with a *masters-/doctoral-level education* ***or*** *specialized training in behavioral health who provides care management* services as well as an assessment of needs, including the administration of validated rating scales, the development of a care plan, provision of brief interventions, ongoing collaboration with the treating physician or other QHP, maintenance of a registry, all in consultation with a psychiatric consultant.

- Services are provided *both face-to face and non-face-to-face* and *Psychiatric consultation is provided minimally on a weekly* basis, typically non-face to-face.

PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

99492

Initial psychiatric collaborative care management,

- first *70 minutes in the first calendar month of behavioral health care manager activities*,
- in consultation with a psychiatric consultant, and
- directed by the treating physician or other qualified health care professional, with the following required elements:

PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

99492- Required elements:

- outreach to and engagement in treatment of a patient directed by the treating physician or QHP
- initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- review by the psychiatric consultant with modifications of the plan if recommended;
- entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

99493

Subsequent psychiatric collaborative care management, first 60 minutes in a ***subsequent month*** of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP

PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

99493- required elements:

- tracking patient follow-up and progress using the registry, with appropriate documentation;
- participation in weekly caseload consultation with the psychiatric consultant;
- ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;
- additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;

PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

99493- required elements:

- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- monitoring of patient outcomes using validated rating scales
- relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment

PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

- 99494

Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)

COCM- Medicare Fee Schedule

2018 CPT Code	Medicare G Code 2017	2018 Relative Value Units	2018 Allowed Amount
99492	G0502: initial PCCM ≥70 minutes per calendar month	3.98	$142.84
99493	G0503: subsequent PCCM ≥60 minutes per calendar month	3.52	$126.33
+99494	G0504: each additional 30 minutes	1.84	$66.04

CPT midpoint rule applies

General Behavioral Care Management

#• 99484

Care management services for behavioral health conditions, at least ***20 minutes*** *of clinical staff time*, directed by a physician or other qualified health care professional, per calendar month

- Moved into CPT from HCPCS code G0507 with 2017 Medicare payment of $46.07

Behavioral health Care Management Required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales.
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes.
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation.
- Continuity of care with a designated member of the care team

Behavioral health Care Management

- Behavioral health integration care management (99484) and psychiatric collaborative care management (99492, 99493, 99494) may not be reported by the same professional in the same month.

- Behavioral health care integration clinical staff are not required to have qualifications that would permit them to separately report services (eg, psychotherapy), and …….

- if qualified and they perform such services, they may report such services separately, as long as the time of the service is not used in reporting 99484

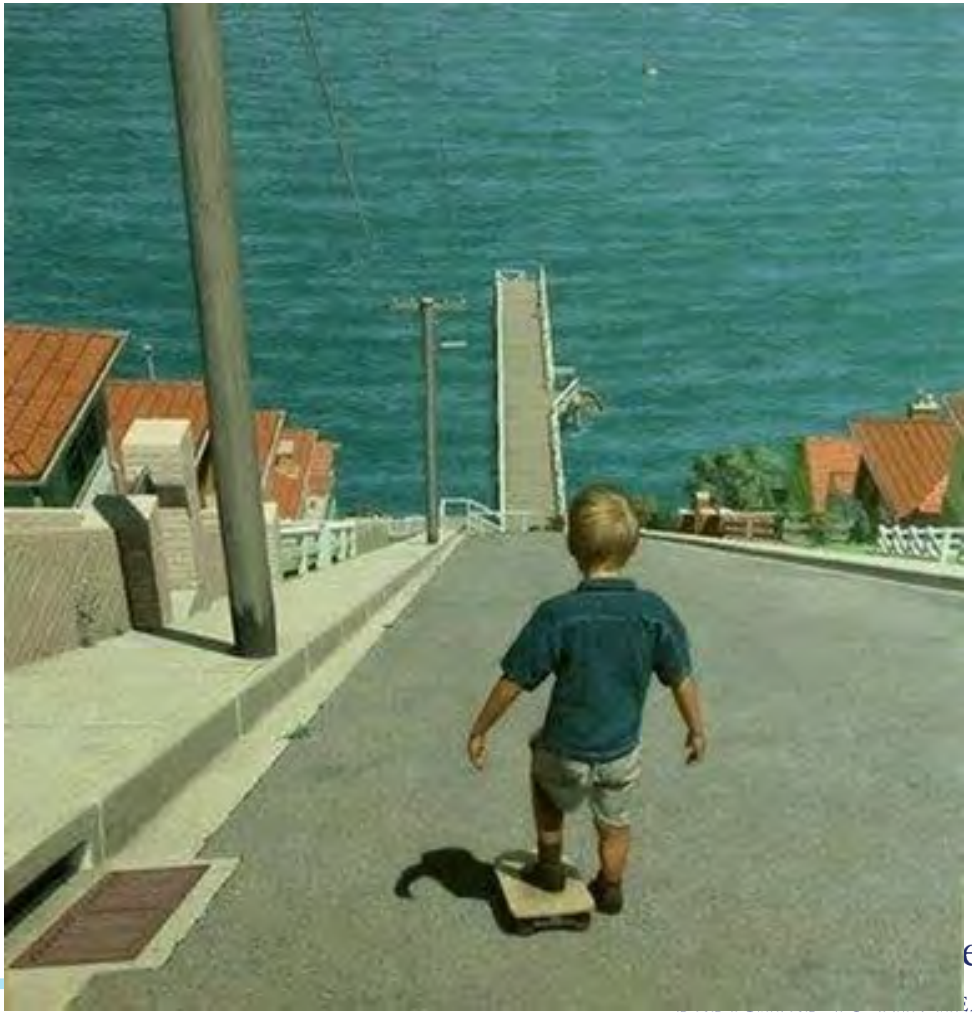
Behavioral health Care Management

- General behavioral health integration care management services (99484) are *reported by the supervising physician* or other qualified health care professional.
- The services are performed by clinical staff for a patient with a behavioral health (including substance use) condition that requires care management services (face-to-face or non-face-to-face) of 20 or more minutes in a calendar month.
- A treatment plan as well as the specified elements of the service description is required. The assessment and treatment plan is not required to be comprehensive and the office/practice is not required to have all the functions of chronic care management (99487, 99489, 99490).
- Code 99484 may be used in any outpatient setting, as long as the reporting professional has an ongoing relationship with the patient and clinical staff and as long as the clinical staff is available for face-to-face services with the patient.

EM Codes for office and hospital care

- No major change for 2018
- CMS plan to revisit the EM Documentation guidelines
- Focus will be to increase the importance of the Medical Decision Making relative to the histroy and physical examination
- Although not requirement (yet), consider MDM to **the** element that reflects the complexity of a given problem , and the drives the EM code selection. Learn the documentation requirement for this key element

ICD 10 CM



ICD-10-CM: New codes for 2018

Clinical need → code development

The October 1, 2017 release is the culmination of 5 years worth of meetings/proposals

https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-PCS-Update-Summary.pdf

total ICD codes- 78,705

- 3562 New codes
- 1821 Revised codes
- 645 deleted*

ICD 10 CM- 2018 Additions

Released July 2017 and implemented 1 October 2017- Highlights

- Umbilical granuloma will be reported with code P83.81, and P83.88 will be reported for other conditions such as bronze baby syndrome, neonatal scleroderma or urticaria neonatorum
- Two new codes were added for reporting non-palpable testis (R39.83-R39.84).
- Acute respiratory distress will be specifically reported with code R06.03.
- Pediatric-specific criteria were added under the subcategories for coma scale for both best verbal response (R40.22-) and best motor response (R40.23-).
- Brief resolved unexplained event (BRUE) was added as an inclusion term under R68.13 (Apparent life threatening event in infant).
- Exercise counseling will be reported with code Z71.82, allowing use of claims data to track provision of exercise counseling in Healthcare Effectiveness Data and Information Set (HEDIS) or other quality measures.

ICD 10 CM- 2018 Additions

Released July 2017 and implemented 1 October 2017- Highlights Cont'd

- Picky eater was added as an inclusion term at code R63.3.
- 7th character (A,D,S) will be required for code T07 (Unspecified multiple injuries) as well as codes in category T14 (Injury of unspecified body region).
- New codes were added to further classify blindness and low vision.
- In remission was added for each substance in the mental health chapter to indicate when a patient with a former dependence is now in remission.
- New codes were added to both myocardial infarction and pulmonary hypertension.
- New codes were added for breast lumps
- Risk of dental caries may be specified as low, moderate, high or unspecified using codes Z91.841–Z91.849.
- External cause codes are added to category V86 to identify patients as driver, passenger or person injured while boarding or alighting from a dirt bike or all-terrain vehicle.
-

ICD 10 – Pediatric Additions 2018

FY2018: New ICD-10-CM codes and descriptors			
F50.82	Avoidant/restrictive food intake disorder	R06.03	Acute respiratory distress
M33.03	Juvenile dermatomyositis without myopathy	R39.83	Unilateral non-palpable testicle
P29.30	Pulmonary hypertension of newborn	R39.84	Bilateral non-palpable testicles
P29.38	Other persistent fetal circulation	T07.XXX-(A,D,S)	Unspecified multiple injuries
P78.84	Gestational alloimmune liver disease	T14.8XX-(A,D,S)	Other injury of unspecified body region
P83.81	Umbilical granuloma	T14.90X-(A,D,S)	Injury, unspecified
P83.88	Other specified conditions of integument specific to newborn	T14.91X-(A,D,S)	Suicide attempt
P91.811	Neonatal encephalopathy in diseases classified elsewhere	Z71.82	Exercise counseling
P91.819	Neonatal encephalopathy, unspecified	Z91.841	Risk for dental caries, low
P91.88	Other specified disturbances of cerebral status of newborn	Z91.842	Risk for dental caries, moderate
Q53.111	Unilateral intraabdominal testis	Z91.843	Risk for dental caries, high
Q53.112	Unilateral inguinal testis	Z91.849	Unspecified risk for dental caries
Q53.13	Unilateral high scrotal testis		
Q53.211	Bilateral intraabdominal testes		
Q53.212	Bilateral inguinal testes		
Q53.23	Bilateral high scrotal testes		

New CPT for 2017 and Expanded Payment Coverage- A Worthy Lookback

- Telemedicine-expanding coverage
- Care management – expanding coverage
- Non Face to Face Prolonged Services-expanding coverage

TELEMEDICINE

- Major changes have been made to the 2017 code manual
- New Appendix (**P**)
  - This appendix was developed to list all the codes that are applicable to the new *telemedicine modifier*
- New symbol (a star★)
  - This symbol denotes codes that are listed in appendix **P**
- New Modifier (**95**)
  - The new modifier to denote when a service was provided via real-time interactive telecommunications system

Telemedicine- Appendix P

Appendix P includes codes for services commonly performed by pediatric physicians, including-

★

- New and established patient office or other outpatientevaluation and management services (**99201–99205**,**99212–99215**)

- New and subsequent hospital care (**99231–99233**)

- Inpatient and outpatient consultations (**99241–99245**, **99251–99255**)

Telemedicine- Appendix P

Appendix P –other CPT codes

- Prolonged services in the office or outpatient setting ★

(**99354**, **99355**)

- Individual behavior change interventions (**99406–99409**)

- Transitional care management services (**99495**, **99496**)

- Remote real-time interactive video-conferenced critical care codes (**0188T**, **0189T**)

Telemedicine – Modifier 95

- **Telemedicine Service Rendered Via a Real Time Interactive Audio and Video Telecommunications System**.
- Modifier **95** may only be appended to the services listed in Appendix **P**. Appendix **P** is the list of CPT codes for services that are typically performed face-to-face but may be rendered via a real time (synchronous) interactive audio and video telecommunications system.

Telemedicine – Modifier 95

Telemedicine Service Rendered Via a Real Time Interactive Audio and Video Telecommunications System:

- Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional.
- The totality of the communication of information exchanged between the provider or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction

Telemedicine – Other Codes

- **HCPCS) code Q3014- Originating Site**

the telehealth originating site facility fee (*CPT 2017* does not include codes for reporting an originating

facility fee)

report for hosting the patient during the telemedicine service (eg, providing conference or examination room, staff, etc to accommodate the telemedicine service).

- **HCPCS code T1014 – For internet line**

Physicians at an originating site may also be able to report the transmission service (eg, cost of telecommunications service) using (telehealth transmission, per minute, professional services bill separately), billing one unit for each minute of service.

Chronic Care Management: required elements

CPT **99490**

- At least 20 minutes of clinical staff time directed by a physician/QHP, per calendar month, with the following required elements:
- At least 2 chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored

Care Management Services

- Chronic (99490) and Complex Chronic Care (99487, 99489)
- Provided by clinical staff under direction of physician or QHP
- Patient at home, rest home, or assisted living facility
- A plan of care must be documented and shared with the patient and/or caregiver.
- Reported only once per calendar month and only by the physician/QHP who assumes the care management role
- Do not count any clinical staff time on E/M visit day for time that would otherwise bundled into the E/M

Complex Chronic Care Management: required elements

CPT: **99487**

- At least 2 chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Establish or substantial revision of comprehensive care plan (do not report CCCM if the care plan is unchanged or minimal change)
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

+99489: each additional 30 mi clinical staff time

Transitional Care Management

99495: requires the following:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge
- And per Medicare: certain non-F2F services as medically indicated

99496: requires the following:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge
- And per Medicare: certain non-F2F services as medically indicated

Prolonged Service without Direct Patient Contact

99358: Prolonged evaluation and management service before and/or after direct patient care; first hour

+99359: each additional 30 minutes (List separately in addition to code for prolonged service)

Service is NOT face-to-face time in the office or outpatient setting nor additional unit/floor time in the hospital

May be reported on a different date than the primary service to which it is related. However, it must relate to a service or patient where (face-to-face) patient care has occurred or will occur.

CMS - The projected payment rate for 99358 is $113.41 (facility and non-facility); for 99359, it is $54.38 (facility and non-facility

Interprofessional Telephone/Internet Consultations

- Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/QHP or other qualified health care professional

CPT	Discussion/review time
99446	5-10 min
99447	11-20 min
99448	21-30 min
99449	≥ 31 min

The written or verbal request for telephone/Internet advice by the treating/requesting physician or other qualified health care professional should be documented in the patient's medical record and written report provided to requesting physician

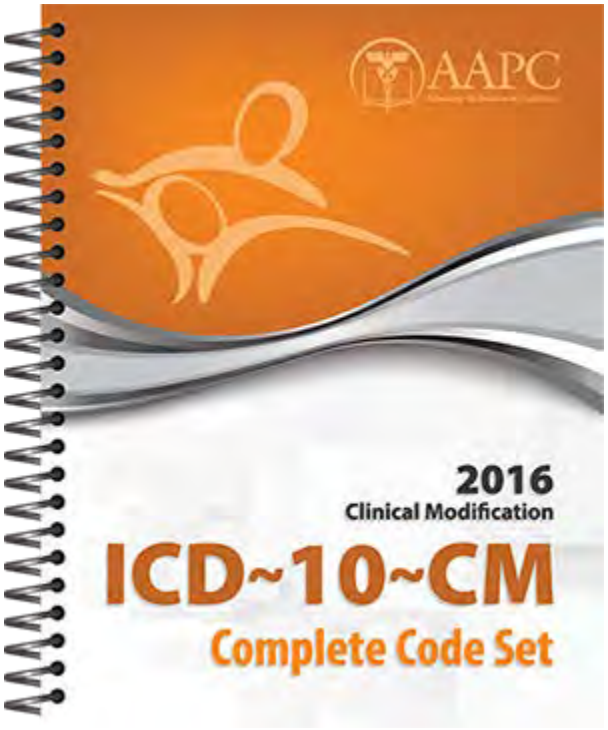
- Medicare Fee Schedule 2016: "B" without published RVUs

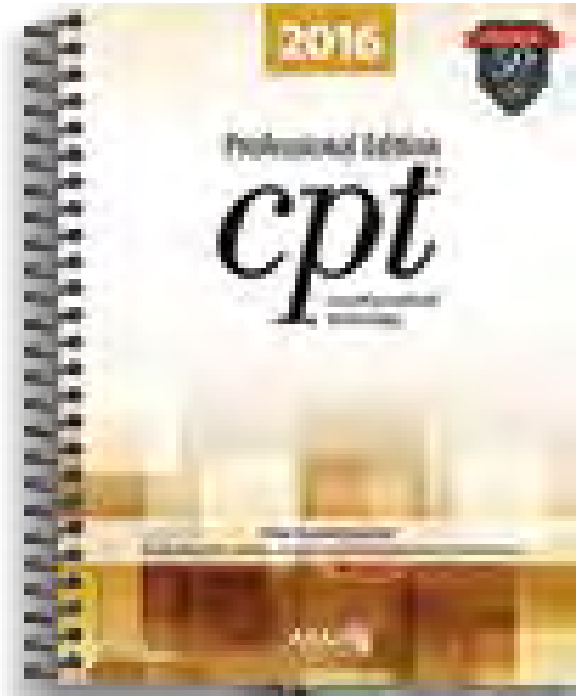
How to Improve Coding and Payment

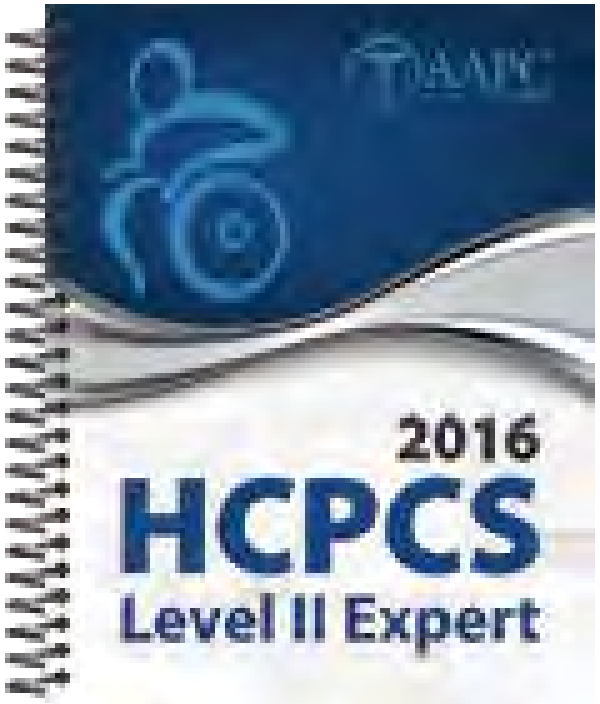
Refresh business system with new code sets now , and have regular coding education

Review all Value based programs and learn the defined coding inputs so you capture clinical quality gap cosures

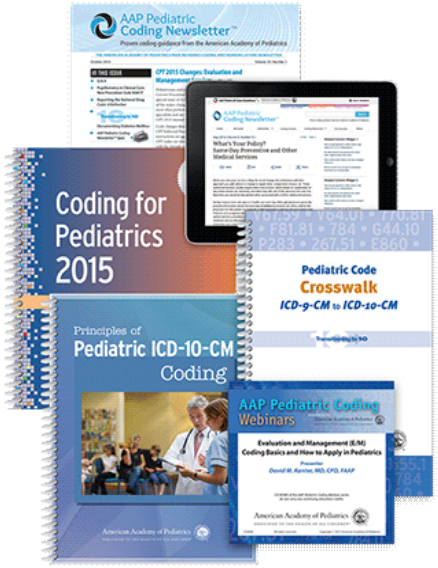
Practice Population health, team based care, and improve the care model for your attributed or assigned populations


AAPC
2016
Clinical Modification
ICD~10~CM
Complete Code Set


2016
Professional Edition
cpt


2016
HCPCS
Level II Expert

AAP Pediatric Coding Publications



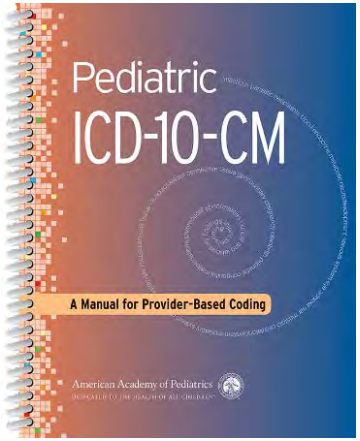
AAP Pediatric Coding Newsletter™
Stay current with all the latest in pediatric coding and compliance.

Coding for Pediatrics, 2016

In its 21th edition, this signature coding publication complements standard coding manuals with proven pediatric-specific documentation and billing solutions.

Pediatric Code Crosswalk ICD-9-CM to ICD-10-CM

Simplify *ICD-9-CM* coding AND prepare for *ICD-10-CM* transition!



Principles of Pediatric ICD-10-CM Coding

A practical desktop handbook and an efficient training tool, it provides a wealth of pediatric-focused knowledge for accurate diagnosis coding.

Pediatric ICD-10-CM: A Manual for Provider-Based Coding

In its first edition, this manual will assist pediatric providers, coders, and billing staff with a condensed version of the ICD-10-CM manual so that they can confidently manage the transition with accurate pediatric diagnostic coding.

AAP Coding Resources

- Coding At the AAP Site

  - One stop shop for all coding related resources from the AAP!

- AAP Coding Hotline aapcodinghotline@aap.org

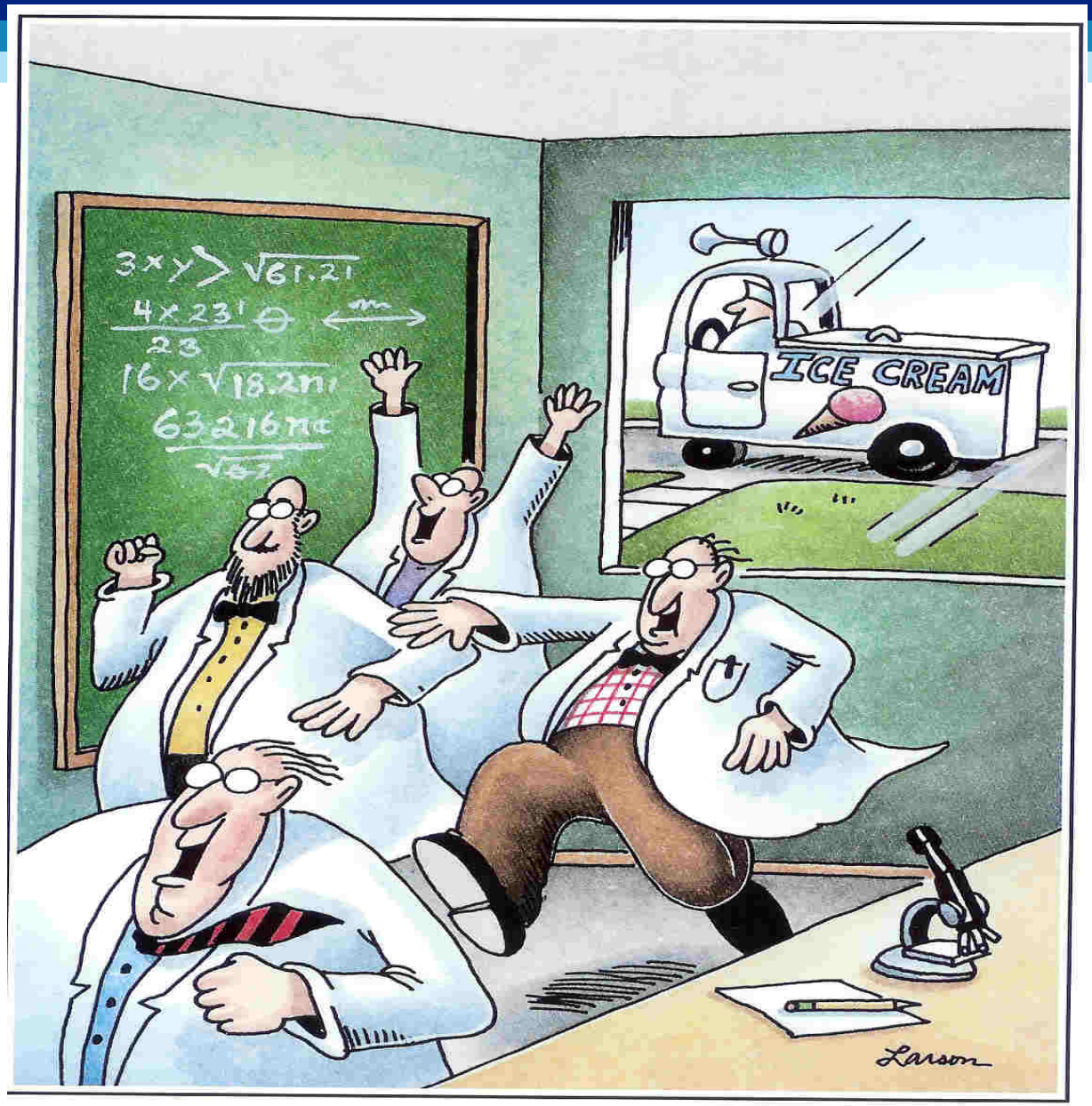
Change…Is Constant in Health Care

"It is not necessary to change… Survival is not mandatory"

- Edward Deming

- Speaking to a group of Detroit automaker executives 1970s

(there will likely be no "Pediatric" bailout)



So…Thank You!!

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Appendix

SCHEDULE

American Academy of Pediatrics
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Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																															
Developmental Screening[9]								●			●		●																		
Autism Screening[10]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]																						★	★	★	★	★	★	★	★	★	★
Depression Screening[12]																						●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]																															
Newborn Blood Screening[15]		←	●	→																											
Critical Congenital Heart Defect Screening[16]		●																													
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[19]							★	★	● or ★[20]		★	● or ★[20]		★	★	★	★															
Tuberculosis Testing[21]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[22]												★			★		★		★	←	●	→	★	★	★	★	★	★	←	●	→	
STI/HIV Screening[23]																	★		★	★	★	★	★	★	★	★	←	●	→	★	★	★
Cervical Dysplasia Screening[24]																															●
ORAL HEALTH[25]							★	★	● or ★		● or ★	● or ★	● or ★	●			●														
Fluoride Varnish[25]							←		●		→																				
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and first mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597) and "Procedures for Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/119/2/389.full).
8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
11. A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
13. At each visit, age-appropriate physical examination is essential, with infant totally undressed and older children undressed and suitably draped. See 2016 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/137/4/e20160281.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendations/panelcurrent.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/127/5/1190.full).
17. See dates, per the AAP Committee on Infectious Diseases, are available at: http://redbook.aappublications.org/site/resources/sizchedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.
18. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030112.pdf).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart, Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/128/4/e1023.full) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/5/993.full).
25. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessment_ped.pdf) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full), 2014 clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/5/e1556), and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224.full).
26. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspschcon.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/6/e1556).

KEY ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ← ● → = range during which a service may be provided

Preventive Medicine Services

New Patient

Initial E/M of a new patient including an age and gender appropriate history and exam, identification of risk factors, ordering of studies/labs, and anticipatory guidance

99381 Age < 1 year

99382 Ages 1 – 4 years

99383 Ages 5 – 11 years

99384 Ages 12 – 17 years

99385 Ages 18 – 39 years

Preventive Medicine Services

Established Patient

Periodic re-evaluation and management requiring an age and gender appropriate history and exam, identification of risk factors, ordering of studies/labs, and anticipatory guidance

99391 Age < 1

99392 Ages 1 – 4 years

99393 Ages 5 – 11 years

99394 Ages 12 – 17 years

99395 Ages 18 – 39 years

Preventive Medicine Services

- Includes
  - Age appropriate anticipatory guidance/Risk factor reduction
  - Age appropriate counseling
  - Review of vaccine history
  - Ordering of appropriate labs and diagnostic procedures
  - Developmental surveillance

Preventive Medicine Service

- What they do not include (bill separately)
  - Individual vaccine (component) counseling
  - Administration of vaccines
  - Vaccine products
  - Screenings or other procedures with its own CPT code (eg, Vision screen, hearing screen, developmental screen)
  - Significant and separately identifiable E/M services to address an acute or chronic problem
  - Unrelated procedures (eg, wart removal)

Preventive Medicine Service

- Is it time for NEW preventive medicine codes
  - Payment policies may deny other related services like EM done at same visit
  - It is administratively complex to bill
  - A growing pediatric morbidity
    - BH conditions- ADHD, ODD, anxiety, depressions, ACES
    - Obesity and Overweight
    - Additional screening services per BF
    - Acute or chronic illness evaluated at same visit as PM
    - Genomic risk profiles drives individualized preventive care
- Is it time to reengineer the CPT codes for preventive care to better value complexity and bundles typical services ??

PM Services and ICD-10-CM

- **Z00.110** Newborn under 8 days old
- **Z00.111** Newborn 8 to 28 days old (NB weight check)
- **Z00.121** Child health examination w/ abnormal findings (Use additional code to identify abnormal findings)
- **Z00.129** Child health examination w/o abnormal findings
- **Z00.00** Adult medical examination w/o abnormal findings
- **Z00.01** Adult medical examination with abnormal findings (Use additional code to identify abnormal findings)

Vaccines and ICD-10-CM Reporting

- For every encounter, ICD-10-CM code **Z23** must be linked to both the product and vaccine administration CPT codes

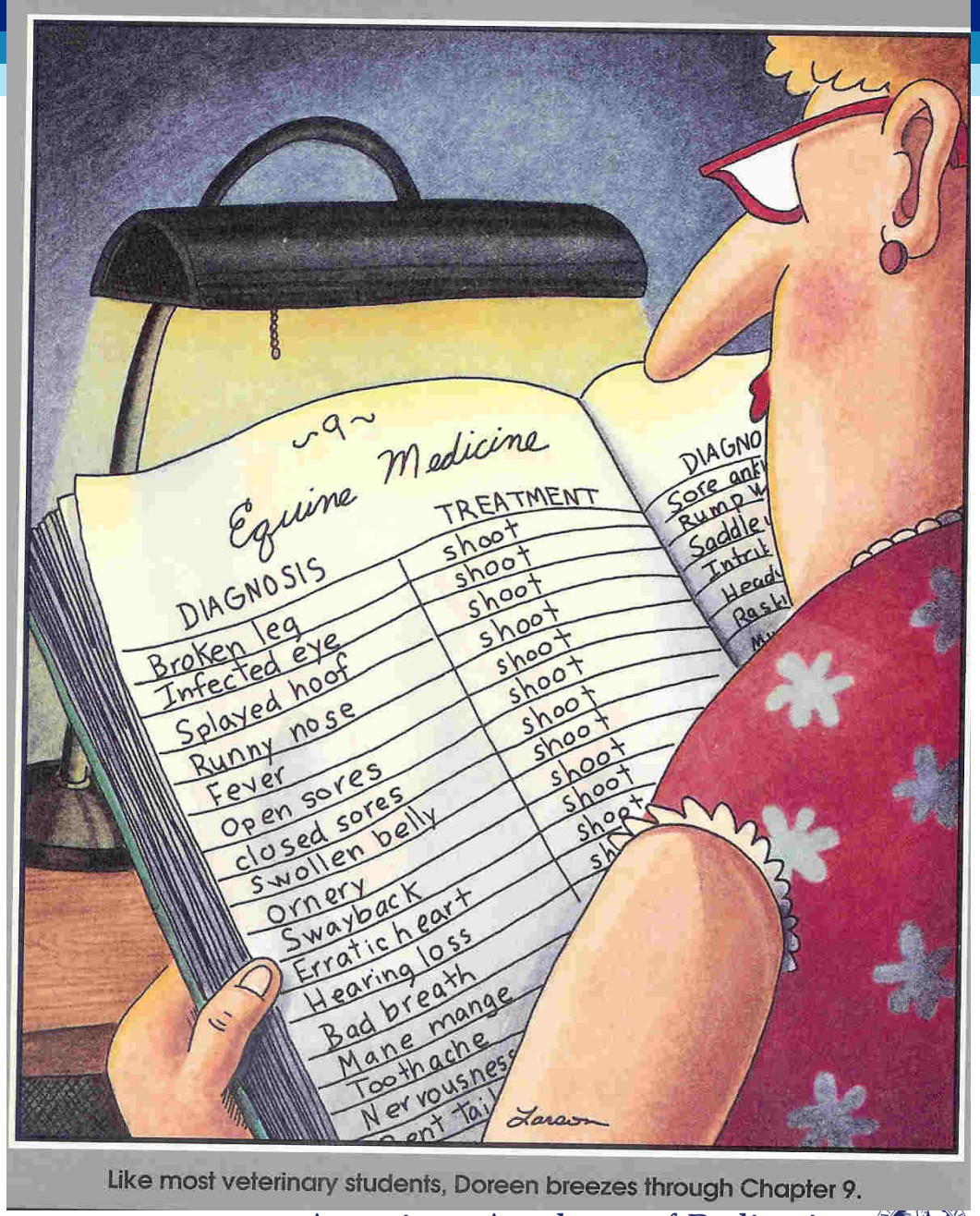
Vaccines not given
ICD 10

- Z28.01 Due to of patient acute illness
- Z28.02 Due to chronic illness or condition
- Z28.03 Due to immune compromised state
- Z28.04 Due to allergy to vaccine or component
- Z28.09 Due to other contraindication
- Z28.1 Due to patient decision for reasons of belief or group pressure

Vaccines not given ICD 10 cont'd

- Z28.20 Due to patient decision for unspecified reason
- Z28.21 Due to patient refusal
- Z28.29 Due to patient decision for other reason
- Z28.81 Due to patient having had the disease
- Z28.82 Due to caregiver refusal
- Z28.89 For other reason
- Z28.9 For unspecified reason

- Like most veterinary students, Doreen breezes through chapter 9



Like most veterinary students, Doreen breezes through Chapter 9.

ICD-10-CM: New codes for 2017 Worthy Lookback

- We have been on an ICD code freeze for the past 5 years
- Clinical need → code development
- The October 1, 2016 release is the culmination of 5 years worth of meetings/proposals
  - 1943 New codes
  - 422 Revised codes
  - 305 deleted*

*codes are not "deleted" in ICD-10-CM, but these 305 codes no longer represent complete codes.

"Deleted" Codes

- Example: Idiopathic acute pancreatitis
- Prior to Oct 1, reported as:
  - **K85.0** (Idiopathic acute pancreatitis)
- On Oct 1, 5th digit required. **K85.0** will be denied as invalid code
- ICD-10-CM formatting:

K85.0 Idiopathic acute pancreatitis

K85.00 Idiopathic acute pancreatitis without necrosis or infection

K85.01 Idiopathic acute pancreatitis with uninfected necrosis

K85.02 Idiopathic acute pancreatitis with infected necrosis

Ch 1 - Certain infectious and parasitic diseases

New code added for Zika virus

- **A92.5 Zika virus disease**

  Zika virus fever, Zika virus infection, Zika NOS

- The AAP is developing new codes for perinatal exposure and perinatal infection as well as an "exposure" code outside of the perinatal period.
- Current, for exposure: **P00.2** (Newborn affected by maternal infectious and parasitic diseases)

Chapter 12 – Diseases of the skin and subcutaneous tissue

New code added at **L03.21** Cellulitis and acute lymphangitis of face

Source: Knoop KJ, Stack LB, Storrow AB, Thurman RJ: *The Atlas of Emergency Medicine, 3rd Edition*: http://www.accessmedicine.com

<u>New Code:</u>

L03.213 Periorbital cellulitis

- Includes preseptal cellulitis

The severity of this condition merited the inclusion of this code

Chapter 16 - Certain conditions originating in the perinatal period

- New Guideline at Categories **P00-P04** *Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery*
- "These codes are for use when the listed maternal conditions (or birth process) are specified as the cause of confirmed morbidity or potential morbidity which have their origin in the perinatal period (before birth through the first 28 days after birth)."
- *Do not report these codes if the condition has been ruled out (Refer to **Z05**)*

Ch 21 - Factors influencing health status and contact with health services

- **Z05** Encounter for observation and evaluation of newborn for suspected diseases and *conditions ruled out*

Guideline:

- *This category is to be used for newborns, within the neonatal period (the first 28 days of life), who are suspected of having an abnormal condition unrelated to exposure from the mother or the birth process, but without signs or symptoms, and which, after examination and observation, is ruled out.*
- **Excludes2**: newborn observation for suspected condition, related to exposure from the mother or birth process (**P00-P04**)
- Example: observing for development of Neonatal Abstinence Syndrome; observing for development of sepsis.

Observation & Evaluation of Newborn

Z05.6 Observation and evaluation of NB for suspected genitourinary condition R/O

Z05.71 suspected skin/subcutaneous tissue R/O

Z05.72 suspected musculoskeletal condition R/O

Z05.73 suspected connective tissue condition R/O

Z05.8 other specified suspected condition R/O

Z05.9 unspecified suspected condition R/O

Observation & Evaluation of Newborn

Z05.0 Observation and evaluation of newborn for suspected cardiac condition ruled out

Z05.1 suspected infectious condition R/O

Z05.2 suspected neurological condition R/O

Z05.3 suspected respiratory condition R/O

Z05.41 suspected genetic condition R/O

Z05.42 suspected metabolic condition R/O

Z05.43 suspected immunologic condition R/O

Z05.5 suspected gastrointestinal condition R/O

Chapter 16 - Certain conditions originating in the perinatal period

- New codes were added at **P05.0** *Newborn light for GA* and **P05.1** *Newborn small for GA*

New Codes:

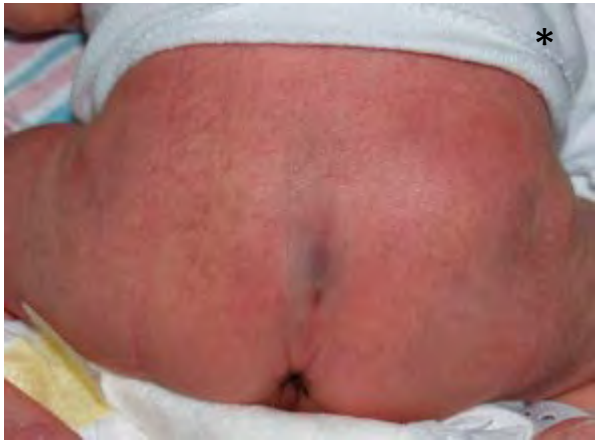
- **P05.09** Newborn light for gestational age, 2,500 grams and over (wt < 10%tile)

- **P05.19** Newborn small for gestational age, other (wt. and ht. <10%tile)

  (Newborn small for gestational age, 2500g and over)

Ch 17 - Congenital malformations, deformations and chromosomal abnormalities

Other new codes:



- **Q82.6** Congenital sacral dimple
  - Parasacral dimple

- **Q87.82** Arterial tortuosity syndrome

*Pediatrics in Review 2011;32;109

Ch 21 - Factors influencing health status and contact with health services

New Codes for Prophylactic Services:

Z29.11 Encounter for prophylactic immunotherapy for respiratory syncytial virus (RSV)

Z29.12 Encounter for prophylactic antivenin

Z29.13 Encounter for prophylactic Rho(D) immune globulin

Z29.14 Encounter for prophylactic rabies immune globin

Z29.3 Encounter for prophylactic fluoride administration

Z51.6 Encounter for desensitization to allergens

Ch 21 - Factors influencing health status and contact with health services

New family history codes:

- **Z83.42** Family history of familial hypercholesterolemia
- **Z84.82** Family history of sudden infant death syndrome

Ch 7 – Diseases of the Eye and Adnexa

- **Amblyopia, suspect**
- **H53.041** - Amblyopia suspect, right eye
- **H53.042** - Amblyopia suspect, left eye
- **H53.043** - Amblyopia suspect, bilateral
- These codes were created to be able to show that the physician is concerned that the child has significant factors for amblyopia and wants to ensure proper follow-up.

Ch 8 – Diseases of the ear and mastoid process

- New Codes at **H90.A**
  - **H90.A11** - Conductive hearing loss, right ear, with restricted hearing on the contralateral side
  - **H90.A12** - left ear
  - **H90.A21** - Sensorineural hearing loss, right ear, with restricted hearing on the contralateral side
  - **H90.A22** - left ear
  - **H90.A31** - Mixed conductive and sensorineural hearing loss, right ear, with restricted hearing on the contralateral side
  - **H90.A32** - left ear

Chapter 9 – Diseases of the circulatory system

- A new category was added
- **I16** *Hypertensive crisis*

New Codes:

- **I16.0** - Hypertensive urgency
- **I16.1** - Hypertensive emergency
- **I16.9** - Hypertensive crisis, UNSPEC

Chapter 11 – Diseases of the digestive system

- At **K02** *Dental caries* – a new includes note was added as follows

Includes: caries of dentine

early childhood caries

pre-eruptive caries

recurrent caries

Z29.3- prophylactic fluoride administration

Chapter 11 – Diseases of the digestive system

- New codes were added under **K52.2** *Allergic and dietetic gastroenteritis and colitis*
- **K52.21** - Food protein-induced enterocolitis syndrome
- **K52.22** - Food protein-induced enteropathy
- **K52.29** - Other allergic and dietetic gastroenteritis and colitis

Chapter 11 – Diseases of the digestive system

- New codes added at **K58** *Irritable bowel syndrome*

New Codes:

- **K58.1** Irritable bowel syndrome with constipation
- **K58.2** Mixed irritable bowel syndrome
- **K58.8** Other irritable bowel syndrome

Chapter 11 – Diseases of the digestive system

- New codes added at **K59.0** *Constipation*

New Codes:

- **K59.03** Drug induced constipation
  - Use Additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)
- **K59.04** Chronic idiopathic constipation
  - Includes functional constipatin

Ch 14 – Diseases of the Genitourinary System

- New subcategory and codes added at **N50.8** *Other specified disorders of male genital organs*
- New Subcategory*:* **N50.81** *Testicular pain*

New Codes:

- **N50.811** Right testicular pain
- **N50.812** Left testicular pain
- **N50.819** Testicular pain, unspecified
- **N50.82** Scrotal pain
- **N50.89** Other specified disorders of the male genital organs

Ch 20 - External causes of morbidity

- **W26.2** Contact with edge of stiff paper

paper cut

- **W26.8** Contact with other sharp object(s), not elsewhere classified
- Contact with tin can lid
- **W26.9** Contact with unspecified sharp object(s)

Ch 20 - External causes of morbidity

- **X50.0** Overexertion from strenuous movement or load
  - Lifting heavy objects or weights
- **X50.1** Overexertion from prolonged static or awkward postures
  - Prolonged or static bending
  - Prolonged or static kneeling
  - Prolonged or static reaching
  - Prolonged or static sitting
  - Prolonged or static standing
  - Prolonged or static twisting
- **X50.3** Overexertion from repetitive movements
- **X50.9** Other and unspecified overexertion or strenuous movements or postures

EM- Office- 99201-99215
CMS Evaluation and Management Documentation Guidelines

- EM Documentation Guidelines
  - Centers for Medicare and Medicaid Services (CMS)
    - » formerly Health Care Finance Administration (HCFA)
  - Have become the de facto industry standard
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html

CMS and clinical presentation
Four Principles

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.

It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. ***(EM Upcoding- MDM explains best the work needed)***

The volume of documentation should not be the primary influence upon which a specific level of service is billed. (*targets extraneous EMR driven History and Examination)*

Documentation should support the level of service reported.

Medicare Claims Processing Manual 30.6.1(A)

Interprofessional Telephone/Internet Consultations

- Review of pertinent medical records such as laboratory studies, imaging studies, medication profile, pathology specimens, and other patient data is included in the telephone/Internet consultation service and is not be reported separately. This review should be performed immediately before or after the telephone/Internet consultation.
- The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal/Internet discussion.
- This service should not be reported more than once within a seven-day interval
- If more than one telephone/Internet contact(s) is required to complete the consultation request, the entirety of the service and the cumulative discussion and information review time should be reported with a single code.

Interprofessional Telephone/Internet Consultations

- Not reportable if consultant has had F2F encounter in past 14 days
- Not reportable by a consultant who has agreed to accept transfer of care before the telephone/Internet assessment, but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial interprofessional telephone/Internet consultation
- Not reportable when the telephone/Internet consultation leads to an immediate transfer of care or other face-to-face service within the next 14 days or next available appointment date of the consultant, these codes are not reported