# Coding for CSHCN

The Colorado Medical Home Initiative

*Every Child Deserves A Medical Home*

# Developed for The Colorado Medical Home Initiative

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# Definition of Children With Special Health Care Needs

Children who have or are at risk for a chronic physical, developmental, behavioral or emotional condition and who also require health related services of a type or amount beyond that required by children generally.

**(MCHB July 1998 - adopted by AAP October 1998)**

## MCHB National Performance Measure

**"All children with special health care needs will receive coordinated, ongoing, comprehensive care within a medical home."**

Healthy People 2010

*Every Child Deserves A Medical Home*

# Colorado Medical Home Initiative

Goal #1: All children with special health care needs in Colorado will have a medical home.

Goal #2: Families of CSHCN will be able to recognize and advocate for a medical home for their child.

Goal # 3: Primary and Sub-Specialty health care providers will recognize the components of a medical home and will implement medical home practices.

Goals #4: Reimbursement for health care for children with special needs will reflect the level of funding necessary to provide medical homes.

# Pediatric Primary Care is

- Designed for 80% of children who **do not** have special health care needs
- Designed to provide well child preventative care services and acute illness management
- Designed to support a single service unit: the provider – patient encounter

# How Does Care Differ Between CSHCN and Typical Children

- More time required to spend on focused problems
- More care coordination and counseling with family
- More care coordination, that is not face to face
- More contact with consultants and other agencies
- More time filing out forms

# Purpose of Coding

- Health Care Providers provide care
- Coding should identify and delineate services being provided
- Correctly code for what you do; Not do what you can code for

# Codes, Fees and Reimbursement

- Codes describes services provided in the care of the patient; CPT is designed to accurately identify the service provided and distinguish that service from other services; Any physician may use any code
- Fees are set by the provider to reflect the value of the services provided
  Fees should be set for each code used by a provider
- Reimbursement is negotiated between the provide and payer

# CSHCN Encounters: Understanding Evaluation and Management (E/M) Codes

# How to Use Evaluation and Management (E/M) Codes When Caring for CSHCN

- Evaluation and Management Codes (introduced in 1992) measure the level of provider work by weighing all pertinent medical findings documented in the history and physical examination sections of medical records in combination with assessment for the complexities and risks of diagnoses and treatments. It is intended to measure the value of clinical cognitive work

# Correct Coding
# Time Versus Key Components

- Two separate approaches that share identical codes
- **Either or** (not to be used together)

# Correct Coding Key Components

- Use the treatment method when the encounter time is focused on addressing a specific and (usually) acute issue

# Example for Coding Using Key Components Method

- Child presents with fever of unclear etiology
- Encounter time is spent in obtaining a history, performing an examination and making treatment decisions to address your findings

# Example for Coding Using Key Components Method

- E&M Code is based upon documentation of required components: Level of History, Examination and Medical Decision Making
- Documentation for Key components needs to match the level of coding

# Correct Coding: Time Method

- Use the time method when more than 50% of the encounter time is spent in counseling and or care coordination
- (not examining the patient)

# Example for Coding Using Time Method

- Child with epilepsy comes in for ED follow up after presenting there with low-grade with fever and signs of mild URI
- Brief and focused evaluation reveals child is doing well but mother is anxious that any fever will bring on a seizure (explaining why she went directly to the ED previously)

# Example for Coding Using Time Method

- You spend additional time (>50% of total time) counseling family around fever in children with epilepsy and setting up an appropriate contingency plan (where going to ED is not the first resort) for subsequent febrile illnesses
- E&M Code is based upon documentation of time spent in counseling and care coordination in proportion to total time spent (i.e. 15 of 35 minute encounter)

# Example for Coding Using Time Method

- If you coded this visit using key component criteria, you would have a problem focused history and examination (perhaps expanded) allowing you to code 99212 (perhaps 99213)
- If E&M Code is based upon documentation of time spent in counseling and care coordination in proportion to total time spent (i.e. 15 of 25 minute encounter), you would code it as a 99214

# Example for Coding Using Time Method

- Documentation of history, examination and medical decision making for the mild illness are for the purpose of recording the medical facts and not relevant in this case to coding documentation
- Documentation (for reimbursement) using time a the criteria should include " 15 minutes out of this 25 minute visit was spent around counseling Ms. Jones about fever and seizures, as well as developing a contingency plan for subsequent febrile illnesses."

# Example for Coding Using Time Method

- You see a child with ADHD (and parent) for a visit that takes 40 minutes
- More than 50% of time was spent in counseling the mother and child about the impact of ADHD and coordinating care, in other words, addressing school issues, home behaviors and other things not directly related to the child's acute health, but as a result of having ADHD

# Example for Coding Using Time Method

- In this case you can bill for a 99215 (established patient)
- Documentation must include diagnosis, description of counseling/coordination done, time spent in CC and total time, and who was present

# Example for Coding Using Time Method

- For example: what needs to be in the record is that " 25 minutes out of this 40 minute visit was spent around counseling Ms. Jones and her son Timmy about school strategies and home behavior modification as it relates to ADHD."

# Example for Coding Using Time Method

- Although you should document all components of H&P performed for medical legal reasons, you DO NOT have to meet all the key components to justify the level 5 codes (Comprehensive history and examination, including of 9 or more systems and/or complex decision making)
- The point to be made here is that E&M coding allows using *EITHER* key components *OR* time codes to justify a level, *NOT* both in the same case

# Example for Coding Using Time Method (with Parent only)

- You see *only* the mother of a child with ADHD for a visit to discuss concerns about medication and school performance that takes 40 minutes
- 100% (more than 50%) of time was spent in counseling the mother about the impact of ADHD and coordinating care, in other words, addressing school issues, home behaviors and other things not directly related to the child's acute health, but as a result of having ADHD

# Definition of Counseling

- "Counseling is a discussion with a patient and/or family concerning one or more of the following area:
  - Diagnostic results impressions and or recommended diagnostic studies
  - Prognosis
  - Risk and benefits of management (treatment) options
  - Instruction for management and/or follow-up
  - Importance of compliance with chosen management
  - Risk factor reduction;
  - Patient and family education"

# Definition of Counseling

- Not counseling along the lines of psychotherapy
- Psychotherapy is coded using 90804-90857

# Example for Care Planning Using Time Method

- The mother of a child with complex medical problems comes in to develop a patient specific care plan for next 6 months
- You have scheduled 40 minutes for this visit
- You sit down with the mother and spend the entire time in developing with the mother and putting into writing a care plan for this child

# Example for Care Planning Using Time Method

- You document that you spent 40 of 40 minutes with Ms. X, mother of child YZ, developing a medical care plan for the child for the next 6 months
- E&M Code is based upon documentation of time spent in counseling and care coordination in proportion to total time spent (i.e. 40 of 40 minute encounter) or 99215

# Care Plan Oversight

- Don’t confuse this with CPT 99374-80 (care plan oversight)!
- Care plan oversight codes are reported separately from codes for office/outpatient, hospital, home, nursing facility, or domiciliary services.
- 99374 and 99375 are used specifically for a child who receives home health care

# Correct Coding
# Time Versus Key Components

- You see a child with ADHD (and parent) for a medication follow-up, scheduled for 20 minutes
- You note that the child is complaining of chest palpitations are are concerned this is a possible side effects of Ritalin
- You note a facial tic during the assessment and then perform a more complete neurological examination

# Correct Coding
# Time Versus Key Components

- You ultimately spend 40 minutes on this visit and 10 minutes was spent discussing side effects of Ritalin including tachycardia and tics
- ICD-9CM codes
  1. Tachycardia
  2. (emergence of a) motor tic
  3. ADHD

# Correct Coding: Key Component

- This visit is acute complaint focused and counseling does not encompass >50% of the time
- You would bill a 99215 *if* your documentation for Key components can match that level of coding
- If not, you would use 99213 and *add* a prolonged physician service charged

# Prolonged Physician Service Charges

- When (outpatient) face to face care provided is prolonged beyond what is usual for any CPT, then the following codes should accompany the appropriate E/M CPT:
- 99354 (30-74minutes)
- 99355 (each additional 1-29 minutes)
- Based upon the total amount of time spent *beyond* what is usual for that CPT
- For example an additional 105 –134 minutes is coded using 99345 (X1) and 99355 (X2)

# Summary

- How to Increase Your Efficiency ($/relative value unit)
- Document Your Services: the Golden Rule: if you don't document it, you didn't do it!

# Summary

- Code Correctly: follow CPT guidelines, use the most specific ICD code possible, use modifiers when appropriate
- Know Your Carriers: know your contracted fee schedule, check every EOB (explanation of benefits), develop a relationship with one person at every carrier, file appeals (and keep on top of them!)

# Summary

- Use the time method when more than 50%of the encounter time is spent in counseling and/or care coordination
- Use prolonged physician service codes when additional care is beyond 30 minutes for that procedure/service

# Coding Resource:

- AAP Coding Hotline
- Phone: 800/433-9016ext. 4022
- Fax: 847/228-9651
- E-mail: aapcodinghotline@aap.org

# For Further Information Contact:

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