HFS Billing and Coding Guidance for Pediatric Obesity Prevention & Management

Improving the Quality of Care for Prevention and Treatment of Childhood Obesity

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Illinois chapter, American Academy of Pediatrics (ICAAP)
Project Funding

This project is funded by a grant from the Otho S.A. Sprague Memorial Institute and the Illinois Department of Healthcare and Family Services.
Disclosure Information

• I have no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider of commercial services discussed in this CME activity.

• I do not intend to discuss commercial products or services and unapproved/investigative uses of a commercial product/device in my presentation.
Program Goals


• Assist providers with necessary education on required documentation for clinic visits related to obesity care and management.

• Aid providers in establishing effective obesity prevention and management services using various methods.
Learning Objectives

By the end of this presentation, providers should be able to:

- Recognize HFS reimbursement policies as they relate to services rendered for assessment and management of pediatric obesity.

- Determine the required elements for Evaluation and Management (E/M) services provided to address pediatric obesity during:
  - Well-child visit initial (CPT 99381–99397)
  - Initial office visits (CPT 99201–99205)
  - Follow-up visits (CPT 99211–99215)
Learning Objectives (cont’d.)

- Understand how to bill and code for obesity prevention and management services consistent with recommended clinical guidelines such as:
  - Assessment of risk factors
  - Physical activity, screen time, and nutritional counseling
  - Screening for associated mental health issues

- Understand the importance of documenting and reporting BMI percentile classification, in accordance with the HFS CHIPRA Quality Measure, BMI Assessment for Children/Adolescents, and its relationship to the 278 code.
Topics

- HFS CHIPRA Quality Measure
  - BMI Assessment for Children/Adolescents

- Documentation Requirements
  - E/M Level of Service
    - Office visits
    - Billing based on time
  - Diagnosis Selection
    - Pediatric BMI Codes [v85.xx]
    - Obesity Specific Codes [278.xx]
    - Comorbidities
Topics

● Reimbursement Overview
  ● Coverage for E/M vs. Risk Assessment Codes
  ● Provider Specialty Coverage (i.e. dieticians, NPP/PA, etc.)

● HFS Future Implementations
  ● New rates for primary care providers (CMS final rule)
Pediatric obesity in this country has grown at staggering rates. Since the 1970’s, the number of obese children has tripled.

The result?

- Increase in pediatric chronic conditions such as juvenile diabetes, respiratory illnesses and even depression.

The solution?

- Providers must aim to identify risk factors and improve the health of our children by working to build awareness along with long term and comprehensive efforts to address this issue.
Where We Are Going

Physicians and healthcare providers across the nation are employing various tactics in order to address the issue of obesity in our pediatric population by:

- Identifying risk of obesity through regular screening of BMI in young children and adolescents
- Implementing evidence-based nutrition and physical activity strategies
- Helping to change environments where our children live, learn, and play.

The first line of defense starts with your office visits!
HFS CHIPRA Quality Measure

BMI Assessment for Children/Adolescents
HFS CHIPRA Quality Measure

- Illinois CHIPRA Quality Demonstration Project
  - Includes BMI assessment as one of the initial core set of 24 children’s quality measures reported to CMS.
  - Measure assesses and classifies weight based on BMI percentile for age and gender (e.g., underweight, normal weight, overweight, obese)
HFS CHIPRA Quality Measure

- HEDIS® (Healthcare Effectiveness Data and Information Set) measure assessment
- HFS reporting of measure
  - Collecting and reporting on measure annually to CMS from administrative billing claims.
- HFS Provider Notice to be published soon on reporting requirements for obesity care with documentation requirements.
In order to meet this goal, physicians should:

- Append a BMI-related secondary diagnosis code to at least one outpatient episode or encounter of care during the calendar year.

- Document and report BMI percentiles on pediatric patients (ages 3 – 17 years) during well-child visits, as well as during other appropriate evaluation and management services.
Reporting Requirements for HFS CHIPRA Quality Measure

- Report of appropriate ICD–9 codes on insurance claims
  - V85.51
    - Pediatric BMI < 5th percentile
  - V85.52
    - 5th percentile < Pediatric BMI < 85th percentile
  - V85.53
    - 85th percentile < Pediatric BMI < 95th percentile
  - V85.54
    - Pediatric BMI ≥ 95th percentile
- When HFS operationalizes ICD–10–CM code series, Z68 will be effective for BMI assessment.
Identifying Risk Factors – Preventive Care Visits

Each Well-Child or Preventive Care Visit should include:

- Documentation and interpretation of BMI percentile or plotting and BMI trajectory
  - BMI percentile can be plotted on a chart or calculated by using readily available online calculators.

- Document and report additional diagnoses or underlying diseases associated with BMI percentiles, such as obesity or any comorbidities that may exist

- Screening for obesity-related co-morbidities

- Nutrition and physical activity assessment and counseling
Follow-Up Office Visits

Subsequent visits for obesity prevention and management should include the above, plus:

• Assessment of risk factors, such as:
  • Sleep problems
  • Family perceptions/misperceptions about obesity in children
  • Co-morbid mental health issues

• Counseling
Follow-Up Office Visits

• Development and/or assessment of shared goals for each of the following:

  • Physical Activity
  • Screen Time (Computer, TV, video games, etc.)
  • Nutrition
    • Fruit and vegetable intake
    • Diet, including fast food and eating out habits
    • Juice and sugar sweetened beverage intake
Follow-Up Office Visits

Things to also consider may include:

- Laboratory testing and evaluation
- Educational Handouts
- Referral to ancillary services and programs
Evaluation and Management Visits

Documenting Key Components

Documentation must support billed charges.
Which Way Should I Bill?

There are two main ways to fulfill the documentation requirements for billing E/M services:

1. Based on key components of the code
2. Billing based on time

Let’s explore both!
Office Visit Documentation

- Each visit is dependent on a documented history, physical exam, and medical decision making.

- The level of service provided should be medically necessary and pertinent to each unique patient encounter.
  - Therefore, not every patient will receive the same level of E/M.
Office Visit Coding—Medicaid

New vs. Established Patient Codes

- A participant may be designated as a ‘new patient’ only once in a lifetime by an individual practitioner, partner of the practitioner, or collectively in a group regardless of the number of practitioners who may eventually see the participant.

- When a patient is transferred within a group practice setting, a new patient Procedure Code is not to be used. The visit is classified as for an established patient. *HFS of IL Handbook for Practitioners; Chapter A–200, Section A 220.23.*
Office Visit Coding– CPT Definition

- **New Patient Codes**
  In order to be classified as "new," a patient must not have received any professional face-to-face services from the Physician or another Physician of the exact same specialty or subspecialty and who belongs to the same group practice within the past three years.

- **Established Patient**
  A patient can be categorized as "established" if she/he has received professional services from the Physician or another Physician of the exact same specialty or subspecialty and who belongs to the same group practice within the past three years.
Documentation Requirements: E/M Level of Service

E/M code selection is based on three key components:

1. History
   - Chief Complaint (CC)
   - History of Present Illness (HPI)
   - Review of Systems (ROS)
   - Past, Family and Social History (PFSH)

2. Examination

3. Medical Decision Making
Documentation Requirements (cont’d.)

• All three key factors are needed for new patient visits and for office consults.

• Only two of three key factors are needed for established patient visits.
Component One: History

There are **four levels** of history:

1. **Problem focused**
   - Brief HPI (1 – 3 elements)

2. **Expanded problem focused**
   - Brief HPI (1 – 3 elements)
   - 1 system reviewed (pertinent to problem)

3. **Detailed**
   - Extended HPI (4 or more elements)
   - Extended ROS (2 – 9 systems)
   - Pertinent PFSH (1 area of history)

4. **Comprehensive**
   - Extended HPI (4 or more elements)
   - Completed ROS (10 or more systems reviewed)
   - Complete Past, Family and Social History
Chief Complaint (CC)

- **CC** is a concise statement that describes the reason for the encounter or visit. It should be as specific as possible.

- **CC** must be documented for all levels of service and visit types. It is the reason for the visit.

- **CC** should not be inferred. Documentation should clearly reflect the reason for the visit.
Chief Complaint (CC)

- **Good Examples:**
  - Patient here for evaluation of obesity
  - Follow-up on sleep disorder and weight management due to being overweight

- **Bad examples:**
  - Patient here for f/u (for what?)
  - Patient here for injection (for what reason/diagnosis?)
History of Present Illness (HPI)

- **HPI** describes the development of the patient’s present illness, from the first sign/symptom to the current state.

- It can also be the status of one or more chronic conditions under the 97 Guidelines.
History of Present Illness (HPI)

- Elements of HPI:
  - Location
  - Quality
  - Severity
  - Duration
  - Timing
  - Context
  - Modifying factors including medications
  - Associated signs and symptoms.
<table>
<thead>
<tr>
<th>Dimension</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Where is the problem located? It can be in or on the body</td>
<td>Lower back, elbow, stomach, left, right, etc.</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>How long has the Chief Complaint been present?</td>
<td>BMI at 95(^{\text{th}}) percentile since 2011</td>
</tr>
</tbody>
</table>
## Elements of HPI

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing</td>
<td>What is the regularity/frequency of occurrences? What time of day does this occur?</td>
<td>Stomach pain worse after eating, worse at night; always occurs after exercise, recurrent, comes and goes, etc.</td>
</tr>
<tr>
<td>Severity</td>
<td>What is the intensity or degree of the Chief Complaint?</td>
<td>Patient is morbidly obese</td>
</tr>
</tbody>
</table>
## Elements of HPI

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>What are characteristics or description of the Chief Complaint?</td>
<td>Stabbing pain, radiating pain, dull ache, anxiety-producing, throbbing, etc.</td>
</tr>
<tr>
<td>Context</td>
<td>What events surround or impact the Chief Complaint?</td>
<td>Recognizes that he eats more when watching television. Patient does not like vegetables. Eats a lot of fried food at lunch.</td>
</tr>
</tbody>
</table>
## Elements of HPI

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Modifying Factors</strong></td>
<td>What treatment/actions have had an effect (positive or negative) on the Chief Complaint?</td>
<td>Patient has begun exercising twice a week with brother.</td>
</tr>
<tr>
<td><strong>Associated Signs &amp; Symptom</strong></td>
<td>Are there any other symptoms that appear to be related to the Chief Complaint?</td>
<td>Patient experiences shortness of breath during gym. Diagnosed as borderline for diabetes.</td>
</tr>
</tbody>
</table>
History of Present Illness (HPI)

- Brief HPI consists of documentation of the CC as well as 1–3 pertinent details of the complaint, or 1 chronic illness.

- Extended HPI documents the CC as well as 4 or more details about the presenting problem, or the status of 3 chronic or inactive conditions.
Example of HPI Documentation

The patient presents for a follow-up on obesity that was diagnosed 6 months ago \textit{(duration)}. The patient says he also experienced chest pain and shortness of breath \textit{(associated signs/symptoms)} during gym activities. Recent weigh-ins show that the weight has improved \textit{(quality)} with diet and exercise \textit{(modifying factors)}.
**Review of Systems (ROS)**

- **ROS** is an inventory of specific body systems performed by the physician and is intended to bring out related clinical symptoms which the patient may have overlooked or forgotten.

- This information is usually gathered either by questions directly asked to the patient by the physician, other qualified healthcare professional, or by a form that is filled out by the patient or parent.
Review of Systems (ROS)

- **Pertinent Problem**: Inquires about the system(s) directly related to the presenting problem(s). Consists of 1 organ system.

- **Extended ROS**: This includes review of additional organ systems, and is usually 2 – 9 systems directly related to the presenting problem(s).
Review of Systems (ROS)

- **Complete ROS**: This includes a review of 10 systems including the system directly related to the presenting problem(s.)

- The physician could indicate the positive and pertinent negative systems found during the encounter.

- For the remaining systems, a notation “*all other systems reviewed and are negative*” is permissible.
## Review of Systems Recognized

<table>
<thead>
<tr>
<th>System</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>Weight loss/gain, fatigue, increased appetite, general appearance</td>
</tr>
<tr>
<td>Eyes</td>
<td>Blurred vision, crossed eyes, eye pain, discharge, eye strain, wears glasses</td>
</tr>
<tr>
<td>Ear, Nose, Mouth, and Throat</td>
<td>Difficulty swallowing, sore throat, earache, post-nasal drip,</td>
</tr>
</tbody>
</table>
# Review of Systems Recognized

<table>
<thead>
<tr>
<th>System</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>Chest pain upon exertion, palpitations, high/low pressure, swelling of ankles/legs</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Asthma, shortness of breath, wheezing, snoring</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Bloating, change in bowel habits, constipation, stomach pain, nausea, vomiting</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Hematuria, excessive/reduced urination, kidney/bladder infections</td>
</tr>
</tbody>
</table>
## Review of Systems Recognized

<table>
<thead>
<tr>
<th>System</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Musculoskeletal</strong></td>
<td>Joint pain/ache/stiffness, muscle pain/weakness</td>
</tr>
<tr>
<td><strong>Integumentary (Skin)</strong></td>
<td>Hives, redness, lumps, wounds, rashes, change in nail/hair texture, bruising (could also be hematologic)</td>
</tr>
<tr>
<td><strong>Neurological</strong></td>
<td>Blackouts, dizziness, fainting, headache, loss of balance, loss of coordination, less of sensation, numbness, seizures</td>
</tr>
</tbody>
</table>
# Review of Systems Recognized

<table>
<thead>
<tr>
<th>System</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric</td>
<td>Anxiety, depression, forgetfulness, loss of sleep, nervousness</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Diabetes, thyroid condition, excessive hunger/thirst</td>
</tr>
<tr>
<td>Hematologic/Lymphatic</td>
<td>Swollen glands/nodes, nosebleed, bruising</td>
</tr>
<tr>
<td>Allergic/Immunologic</td>
<td>Allergies, autoimmune disorder</td>
</tr>
</tbody>
</table>
Past, Family, Social History (PFSH)

Past Medical, Family, and Social History elements are part of the required elements to be documented for a detailed or comprehensive exam.

- Detailed requires only 2 areas that must be reviewed.
- Comprehensive requires that all 3 areas are be reviewed.
Past, Family, Social History (PFSH)

PFSH should be pertinent and age appropriate.

- **Past History**: past experiences with illnesses, operations, injuries and treatments
- **Family History**: medical events in the patient’s family, including diseases which may be hereditary or place patient at risk
- **Social History**: age appropriate review of past and current activities
Past History

Past History:

- Tonsillectomy in 2002
- Current medications
- Peanut Allergies
- GERD

Past history for infants/newborns may include mother’s pregnancy history
Family History:

- Family hx of obesity with Heart Disease
- MGM with DM
- No family history of respiratory illnesses
Social History

Social History:

• Lives with mom, dad, and sister
• Is in 7th grade
• 3 hours a day of screen time
• Child on football team
It is not necessary to re-document a new ROS and PFSH obtained during an earlier encounter if it is clearly documented that the physician reviewed and updated the previous information.

- Describe any new ROS and/or PFSH information, or
- Note there has been no change in the information, and
- Note the date and location of the earlier ROS and/or PFSH
History Tips

“Refer to PFSH/ROS on _____ (name of document) dated ______ (mm/dd/yyyy). No changes except as noted.”

• If the physician is unable to obtain a history from the patient or other source, documentation should clearly describe the patient’s condition which precludes a history.
Component Two: Physical Exam

The are four levels of examination:

- **Problem Focused**
  - A limited exam of the affected organ system (1 element).

- **Expanded problem focused**
  - A limited exam of the affected organ system and other symptomatic or related organ systems (2–7 elements).
Component Two: Physical Exam

- Detailed Examination
  - An *extended* examination of the affected or symptomatic organ systems (2–7 elements with at least one system in greater detail).

- Comprehensive
  - A general multi-system exam or complete examination or 8+ elements of a single organ system.

- *All abnormal or significant findings must be documented.*
Recognized Organ Systems

- Constitutional (vital signs, general appearance)
- Eyes
- Ears, Nose, Mouth, Throat (ENMT)
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic
Recognized Body Areas–‘97
DG

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

NOTE: Documentation of body areas will not count toward a Comprehensive Exam
Physical Exam Tips

• All abnormal or relevant negative findings of affected or symptomatic body area(s) or organ system(s) should be documented.

• A notation of “abnormal” w/out elaboration is insufficient.

• Abnormal or unexpected findings of unaffected or asymptomatic body area(s) or organ system(s) should also be described.
Physical Exam Tips

- Unaffected or asymptomatic area(s) or organ system(s) can be noted with a statement indicating “negative” or “normal” without elaboration on normal findings.

- Do not use terms such as “unremarkable or noncontributory” without elaboration.

- Physical Examination should be pertinent to the presenting problem and should never be directly copied from a previous visit.
MDM Levels and Components

There are four types of MDM:

- Straightforward
- Low Complexity
- Moderate Complexity
- High Complexity
MDM Levels and Components

To qualify for a given type of decision making, two of the three elements must be met or exceeded:

- Number of diagnoses or management options.
- Amount and/or complexity of data reviewed.
- Risk of significant complications, morbidity and/or mortality.
MDM “Scoring” System

Because **MDM** is difficult to quantify, in general, a scoring or a “point” system is used to judge your cognitive labor that helps determine the complexity of MDM, although the Documentation Guidelines do not specify such.
MDM “Scoring” System

- All major academic centers and large institutions have incorporated this point system into their compliance programs.

- This scoring system is also being used by the CERT (Comprehensive Error Rate Testing) Program.

- Perhaps the most compelling reason to use the MDM Point System is that this is how your cognitive labor will be judged in the event of a Medicare (RAC), Medicaid (MIC) or other payer audit.
## MDM “Scoring” System

<table>
<thead>
<tr>
<th>Problems to Exam Physician</th>
<th>Number</th>
<th>Points</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max=2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); stable, improved</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); worsening</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no addl workup planned</td>
<td>Max=1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); addl workup planned</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

Bring total to line A in Final Result for Complexity.
## MDM “Scoring” System

### Amount and/or Complexity of Data to Be Reviewed

<table>
<thead>
<tr>
<th>Data to Be Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing, or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
</tbody>
</table>

**TOTAL**

Bring total to line C in Final Result for Complexity
## MDM Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| MINIMAL       | *One self–limited or minor problem, e.g. cold, insect bite, tinea corporis | *Lab tests requiring venipuncture  
*Chest x–rays  
*EKG/EEG  
*Urinalysis  
*Ultrasound, e.g. echo  
*KOH prep | *Rest  
*Gargles  
*Elastic bandages  
*Superficial dressings |
| LOW           | *Two or more self–limited or minor problems  
*One stable chronic illness, e.g. well–controlled HTN or DM, cataract, BPH  
*Acute uncomplicated illness or injury, e.g. cystitis, sprain, allergic rhinitis | *Physiologic tests not under stress, e.g. pulmonary function tests  
*Non–cardiovascular imaging studies with contrast, e.g. barium enema  
*Superficial needle biopsies  
*Skin biopsies | *Over–the–counter drugs  
*Minor surgery with no identified risk factors  
*Physical therapy  
*Occupational therapy  
*IV fluids without additives |
# MDM Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| MODERATE      | *One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment  
*Two or more stable chronic illnesses  
*Undiagnosed new problem with uncertain prognosis, e.g. lump in breast  
*Acute illness with systemic symptoms, e.g. pneumonitis, colitis  
*Acute complicated injury, e.g. injury with brief loss of consciousness | *Physiologic tests under stress, e.g. cardiac stress test, fetal contraction stress test  
*Diagnostic endoscopies with no identified risk factors  
*Deep needle or incisional biopsy  
*CV imaging studies with contrast and no identified risk factors, e.g. arteriogram, cardiac cath  
*Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis | *Minor surgery with identified risk factors  
*Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors  
*Prescription drug management  
*Therapeutic nuclear medicine  
*IV fluids with additives  
*Closed treatment of fracture of dislocation without manipulation |
<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| HIGH          | *One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
*Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g. multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, psychiatric illness w/ potential threat to self or others, peritonitis, acute renal failure  
*An abrupt change in neurologic status, e.g. seizure, TIA, weakness, sensory loss | *Cardiovascular imaging studies with contrast with identified risk factors  
*Cardiac electrophysiological tests  
*Diagnostic endoscopies with identified risk factors  
*Discography                                                                                   | *Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors  
*Emergency major surgery (open, percutaneous, or endoscopic)  
*Parenteral controlled substances  
*Drug therapy requiring intensive monitoring for toxicity  
*Decision not to resuscitate or to de-escalate care due to poor prognosis |

Bring result to line B in Final Result for Complexity
# MDM “Scoring” System

## Final Result for Complexity

<table>
<thead>
<tr>
<th></th>
<th>Number diagnoses or management options</th>
<th>≤ 1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>≥ 4 Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Highest risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>C</td>
<td>Amount and complexity of data</td>
<td>≤ 1 Minimal or low</td>
<td>2 Limited</td>
<td>3 Moderate</td>
<td>≥ 4 Extensive</td>
</tr>
<tr>
<td></td>
<td>Type of decision making</td>
<td>Straight-forward</td>
<td>Low Complex.</td>
<td>Moderate Complex.</td>
<td>High Complex.</td>
</tr>
</tbody>
</table>
Number of Diagnosis & Management Options

- Indicate whether the patient’s condition is new or already known to the physician.
- For presenting problems that are established diagnosis, note the status of the condition:
  - Improved, well controlled, resolving or resolved, or
  - Inadequately controlled, worsening, or failing to change as expected.
- The initiation of, or changes in treatment should be documented (i.e. instructions, therapies, meds).
Amount and Complexity of Data

- Document if a test or procedure is ordered, planned, scheduled or performed at the time of the visit.

- Document the review of lab, radiology and/or other diagnostic tests.

- Document the results of discussion of lab, radiology or other diagnostic tests w/physician who performed or interpreted the study.
Amount and Complexity of Data

- Document direct visualization and independent interpretation of an image, tracing or specimen.

- Document a decision to obtain old medical records or obtain additional history from the family, caretaker or other source.

- Document relevant findings from the review of old medical records, and/or receipt of additional history from the family, caretaker or other source. A notation of “old records reviewed” or “additional history obtained from family” w/out elaboration is insufficient.
Risk of significant complications, morbidity and/or mortality

Risk of significant complications, morbidity and/or mortality associated with:

- Presenting problem(s)
- Diagnostic procedure(s) ordered
- Selected management options

The highest level of risk in any one category in the Table of Risk determines the overall risk.

- Minimal
- Low
- Moderate
- High
E/M Key Components

History
- Chief Complaint
- HPI
- ROS
- PFSH
- Problem Focused: 1 area
- Expanded: 2 – 7
- Detailed: 2 – 7 in more detail
- Complete: 8+ systems

Exam
- Number of Diagnosis
- Amount and Complexity of Data
- Level of Risk

Medical Decision Making
Preventive Care Visits

- Preventive Care Codes (99381–99397) do not have the same key factors as other E/M codes.
  - Extent and focus of the services will largely depend on the age of the patient.
  - Comprehensive nature of the codes reflects an age and gender appropriate history/exam.
- Does not include vision and hearing screening. These are separately reportable.
Evaluation and Management Visits
Billing Based On Time
Time Component

There are other contributing factors that may influence your code selection:

- Time
  - Counseling
  - Coordination of care
Billing Based on Time

Definition of Time in an Office Setting:

- **Face–to–face** time occurs when the physician meets directly face–to–face with the patient or family.
  - It applies to office and other outpatient visits.
  - If the visit is dominated by counseling (more than 50%), include the statement “I have spent ___ mins./hrs.) of face–to–face time with the patient. ___ mins. were spent on counseling.”
Counseling: Office Setting

Discussions with the patient and/or parent/caregiver qualifies as counseling if it includes discussions of one of the following:

- Diagnostic results, impressions, and/or recommended diagnostic studies.
- Prognosis & risks/benefits of management options.
- Instructions of treatment/management and/or follow-up.
Counseling: Office Setting

Also includes:

- Importance of compliance with chosen management options & risk factor reduction
- Patient and family education
- Document total face-to-face clinic time and total time spent counseling.
  - Time spent once the physician has begun care for another patient should not be considered.
New Patient Visits

- **99201** = Problem Focused History, physical, and MDM that is straightforward.
  - Typical time spent: **10 minutes**
- **99202** = Expanded problem focused history, physical, and MDM that is straightforward/low.
  - Typical time spent: **20 minutes**
- **99203** = Detailed history, physical, and low MDM.
  - Typical time spent: **30 minutes**
- **99204** = Comprehensive history, physical, with moderate MDM.
  - Typical time spent: **45 minutes**
- **99205** = Comprehensive history, physical, with higher MDM.
  - Typical time spent: **60 minutes**
Established Patient

- **99212** = Problem Focused History, physical, and MDM that is straightforward.
  - Typical time spent: **10 minutes**

- **99213** = Expanded problem focused history, physical with low MDM.
  - Typical time spent: **15 minutes**

- **99214** = Detailed history, physical with moderate MDM.
  - Typical time spent: **25 minutes**

- **99215** = Comprehensive history, physical, high MDM.
  - Typical time spent: **40 minutes**
ICD–9 DOCUMENTATION AND REPORTING

2013 Diagnosis Codes
Documenting Diagnoses

General Documentation Guidelines for ICD–9 Selection:

- Do not code conditions listed as “rule out” or “probable”.
- If obesity has not yet been diagnosed, use as many diagnosis codes that clearly describe the patient’s signs/symptoms or accompanying conditions.
Documenting Diagnoses

• Once obesity has been diagnosed, use the appropriate obesity code plus the v-code that represents the child’s BMI percentile.

• Always list the code for obesity and/or comorbidities as primary diagnosis.

• Sequence BMI percentile as secondary or subsequent code

• List any additional diagnosis codes for co-morbidities that exist.
ICD–9: Obesity

- **278.00**: Obesity, unspecified [BMI between 30.0 and 39.9]
- **278.01**: Morbid obesity [BMI 40 or greater]
- **278.02**: Overweight [BMI between 25 and 29.9]
- **278.03**: Obesity hypoventilation syndrome
- **783.1**: Abnormal weight gain
- **V77.8**: Special Screening for Obesity
Pediatric BMI Percentile Codes
(IL Quality Measure)

- **V85.5**: BMI, pediatric, < 5th percentile for age
- **V85.52**: BMI, pediatric, 5th percentile to less than 85th percentile for age
- **V85.53**: BMI, pediatric, 85th percentile to less than 95th percentile for age
- **V85.54**: BMI, pediatric, ≥ 95th percentile for age
Coverage for Related Services
Reimbursement Overview
HFS Reimbursement

- HFS currently provides reimbursement for E/M services when documentation meets medical necessity requirements of the code selected.
  - It is, therefore, very important that the diagnosis and E/M code selection is supported in the provider’s documentation.

- Currently, there is no coverage for the Preventive Medicine Counseling/Risk Factor Reduction codes 99401 – 99412.
Well–Child with Sick Visits – HFS Policy

Although most private payers pay for both well child and sick visit codes on the same date of service, according to the HFS Handbook for Practitioners, “a preventive medicine CPT Code and an office or other outpatient evaluation and management CPT Code during the same session are not separately reimbursable.”
Provider Specialty Coverage

Coverage for Obesity Related Office Visits:

- HFS currently covers medically necessary office visits when such is documented in the patient’s medical records.
- This includes coverage for obesity related services using the 278.0x ICD–9 code series.

Midlevel Providers (NPP/PA):

- Credentialed Midlevel providers will continue to be reimbursed by HFS when billing independently.
- They will also be allowed to continue to bill “incident to” a physician when all requirements are met.
Provider Specialty Coverage

Registered Dietitian:
- HFS considers counseling rendered by dieticians as a non-covered service.

Physical Therapy:
- Physical therapy services are only covered when they are provided by a licensed Physical Therapist and are “medically necessary”.
- HFS considers services necessary when:
  - “(A) services are required because an illness, disability or infirmity limits functional performance; and (b) when these services will improve functional skills performance.”
New Rates for Primary Care Physicians

Section 1202 of ACA of the new healthcare laws requires state Medicaid agencies to reimburse participating physicians at Medicare rates for primary care services during the 2013 and 2014 calendar years.
New Rates for Primary Care Physicians

Physicians that are board certified in the following specialties will benefit from this requirement:

- Pediatrics, Internal Medicine, or Family Medicine.
- Any physician not meeting the board certification requirement can apply for special consideration if over 60% of codes billed are in the approved E/M CPT code ranges.
- Mid-level providers billing independently will also be included under the law.
Tools and Resources

- OP Documentation & Coding Guide
- HFS Reimbursement Guide for E/M services
- HFS Enhanced Payment
- HFS Provider Handbook:
  - http://www.hfs.illinois.gov/assets/100.pdf
- HFS Practitioner Fee Schedule
  - http://www2.illinois.gov/hfs/MedicalProvider/FeeSchedule/Pages/default.aspx
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