2023 Pediatric Coding Update and Managing the Challenge of Surge

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Agenda

- Review 2023 Pediatric Coding Updates
- Discuss the impact of surge on pediatric practices
- Strategize how your practice can adjust more effectively to times of surge

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Coding Clarifications

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Systemic Symptoms

What supports an acute illness with systemic symptoms (problems addressed moderate/level 4) if fever, body aches, or fatigue may be present in a minor illness?

- Can't be a "history of" fever, must be fever today
- Is fever a common symptom of an acute uncomplicated illness? (Temp 100.6 in preschooler with URI not ill appearing)
- Or does fever raise a reasonable concern for a condition with a high risk of morbidity without treatment? (Temp 102 in a 18 month old with otitis media)
- The reporting physician or QHP must make this determination based on ***the individual patient at each encounter***

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Systemic Symptoms (cont.)

- Since this is on an individual patient basis, you can't really template this
- When in doubt…**spell it out!**
  - *"In this 18 month old with OM and systemic symptom of fever, differential diagnosis also includes complication of systemic bacterial infection/bacteremia. Feel this is unlikely in this patient who is UTD on Imms including HIB and PCV (most common pathogens in this age group.) However, discussed with family need to continue observation and if patient becomes lethargic, fever continues after 48 hours of antibiotics, or patient has increasing irritability, poor feeding, signs of dehydration or acting ill then parents to reach out to office urgently for possible re-evaluation, escalation to higher place of care or change in treatment plan."*
- Other examples:
  - Lethargy: *"systemic symptom of lethargy may be indicative of something more serious in this patient including differential dx of bacteremia or meningitis, dehydration and discussed…"*
  - Poor feeding, irritability, nausea/vomiting, stridor, respiratory distress….

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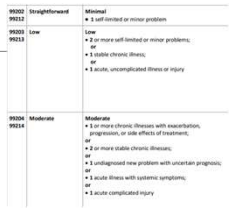
Chronic Conditions

Must conditions presenting in infants (eg, reflux, feeding problems, developmental delays) have lasted 1 year to be considered chronic?

- CPT defines as "an expected duration of at least one year or until the death of the patient"
- When there are clinical indications that you can reasonably expect the condition to last a year, that's considered a chronic condition for the purposes of MDM: ex. Developmental delays
- A problem that may be expected to last less than a year (ex. Neonatal GER) may be either:
  - An acute stable illness (new or recent problem for which treatment has been initiated and is stable but not resolved)
  - An acute illness with systemic symptoms (ex. GER with poor growth)



99202 99212	Straightforward	Minimal • 1 self-limited or minor problem
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury

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Choosing an E/M Level for Sick Visits

- Choose a code based on MDM or time, whichever is more advantageous for each visit
- **Documentation** of MDM **matters**: document decisions including options that were considered but not chosen. This supports higher amount and/or complexity of data to be reviewed and analyzed or higher risk associated with management decisions.
- Listing the 3 elements of MDM used in code selection is not required but can make the reason for code selection **clear in a future chart review or audit** (eg, problem = moderate, worsening asthma symptoms; data = limited, history from parent; risk = moderate, prescription drug management)
- Time is only the physician's or QHP's time directed to the care of the individual patient on the date of the encounter and does not have to be continuous or face-to-face

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Preventive Visits: With & Without Abnormal Findings

- Abnormal findings refer to any **new** physical findings that are not the patient's typical examination results
- A stable chronic condition is not reported as an abnormal finding even when a medication refill is requested
- An exacerbation or progression of a chronic condition is an abnormal finding
- When a stable chronic condition is evaluated at the same encounter as a preventive E/M service, the diagnosis code for the chronic condition is reported in addition to the diagnosis code for a routine health examination ***without*** abnormal findings (ex. Z00.129 and J45.20, uncomplicated mild intermittent asthma)
- Report a code for routine health examination ***with*** abnormal findings (eg, Z00.121) when a **new problem** is diagnosed, an **existing condition is noted to be exacerbated or progressing**, or the patient is experiencing **side effects of treatment**. Use an additional code(s) to report the abnormal findings.

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Coding Updates

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Time Requirements for Prolonged Clinical Staff Service

- Requirement for 99415 and 99416 have changed for 2023
- Represents only the time spent face-to-face with a patient/family/caregiver by clinical staff working under the direct (in-office) supervision of a physician or other QHP
- Separate from what the supervising physician or QHP reports for the related E/M service (99202-99205, 99211-99215)
- When clinical staff perform separately reportable services (eg, injection or inhalation therapy) during an encounter, the time spent in provision of the separately reported service is ***not included in the time of the prolonged clinical staff service***
- Prolonged clinical staff services may be reported for simultaneous services provided to 2 patients, but the time reported for each patient must have been devoted to the single patient

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Prolonged Clinical Staff Time

The "Related Office E/M Code" column includes the code reported for the physician's or QHP's E/M service to which the prolonged clinical staff service is additionally reported. The time range for **99415** *includes at least 30 and up to 74 minutes beyond the typical time. At least 75 minutes beyond the typical time is required to report* **99416**. *Each additional unit of* **99416** *represents 30 minutes beyond the first hour or 15 to 30 minutes beyond the last service period.*

Related Office E/M Code	Typical Clinical Staff Time (min)	Time Range for 99415 (min)	Time Range for 1 Unit of 99416 (min)
99202	29	59–103	104–133
99203	34	64–108	109–138
99204	41	71–115	116–145
99205	46	76–120	121–150
99211	16	46–90	91–120
99212	24	54–98	99–128
99213	27	57–101	102–131
99214	40	70–114	115–144
99215	45	75–119	120–149

Abbreviations: E/M, evaluation and management; QHP, qualified health care professional.

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Example

- Office visit for a 6 yo established patient with vomiting/diarrhea an inability to retain oral fluids at home.
- Pediatrician orders oral rehydration therapy in the office due to mild-to-moderate dehydration.
- Oral rehydration solution is administered by clinical staff who is monitoring the child's intake and output intermittently over the course of 3 hours.
- When the child is tolerating oral rehydration sufficiently to offset stool losses, the physician reevaluates the patient and provides at-home care instructions to the patient's family.
- Pediatrician's level of service is 99214 based on the physician's total time of 30 minutes directed to the patient's care on the date of the visit.
- The clinical staff's total is 90 minutes. Using the 2022 guidelines for code 99415, prolonged clinical staff time begins after the highest amount of time in the range of total time assigned to the code for related office E/M service is passed. (99415 requires a total face-to-face time of at least 30 minutes beyond the 39-minute upper time in the total time range assigned to code 99214, ie, at least 69 minutes of clinical staff time). Code 99415 is reported for the first 60 minutes of prolonged clinical staff service. The remaining 30 minutes of time spent in this example is reported with code 99416.
- The pediatrician reports codes 99214, 99415, and 99416 with 1 unit of service each.

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Guidelines for Home/Residential Visits

- Should ***not*** use regular E/M with just different place of service
- Base on either MDM or Time (does NOT include travel time)

Table of Home and Residence Codes

Code		Level of MDM	Total Time	Non-facility RVUs[a] Work	Total
New patient	**99341**	Straightforward	≥15 min	1.00	1.43
	99342	Low	≥30 min	1.65	2.30
	99344	Moderate	≥60 min	2.87	4.22
	99345	High	≥75 min (see **99417** for ≥90 min)	3.88	5.98
Established patient	**99347**	Straightforward	≥20 min	0.90	1.30
	99348	Low	≥30 min	1.50	2.26
	99349	Moderate	≥40 min	2.44	3.74
	99350	High	≥60 min (see **99417** for ≥75 min)	3.60	5.48

Abbreviations: MDM, medical decision-making; RVU, relative value unit.
[a]RVUs as included in the 2023 proposed rule for the Medicare Physician Fee Schedule. RVUs shown are not geographically adjusted.

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Interprofessional Consultations: 99446–99449 vs 99451

Interprofessional Consultation Codes

Required Communication	Code	Required Time (cumulative min)	Report Required	RVUs[a] Work	Total
Medical consultative telephone, internet, or EHR discussion (verbal) and review	**99446**	5–10 min[b]	Both verbal and written	0.35	0.51
	99447	11–20 min[b]		0.70	1.06
	99448	21–30 min[b]		1.05	1.58
	99449	≥31 min[b]		1.40	2.14
Medical consultative discussion by internet or EHR without a verbal component	**#99451**	≥5 minutes of review and interprofessional communication time	Written only	0.70	1.06

Abbreviations: EHR, electronic health record; RVU, relative value unit.
[a]RVUs shown were taken from the proposed 2023 Medicare Physician Fee Schedule and are unadjusted for geographic locality. RVUs for these services are the same whether provided in a facility or non-facility site of service.
[b]Do not report **99446–99449** when more than 50% of the service is devoted to information review and/or analysis. More than 50% of the physician's or other qualified health care professional's cumulative service time must be spent in verbal or internet discussion.

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Interprofessional Consultations: 99446–99449 vs 99451

Do **not** report an interprofessional consultation when the following are true:

- The sole purpose of the interprofessional communication is to arrange a transfer of care or other face-to-face service
- The time of service is less than 5 minutes
- The patient is an established patient to the consultant and the consultant has provided a face-to-face service (eg, inpatient or outpatient consultation, telemedicine visit) in the 14 days prior to the consultation
- The interprofessional consultation leads to a transfer of care or plans for a face-to-face service (eg, surgery, E/M visit) between the consultant and the patient within the next 14 days or next available appointment date of the consultant
- A prior interprofessional consultation was provided by the consultant or another physician or QHP of the same exact specialty and same group practice within the past 7 days

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Interprofessional Consultations: the Requesting Physician

- May report time spent preparing for the referral and/or communicating with the consultant. Codes reported depend on the amount of time spent and whether a type of face-to-face E/M service was provided on the same date.
- 16-30 minutes prep time/communication w/the consultant: 99452 may be reported. (CPT code 99452 Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/ requesting physician or other qualified health care professional, 30 minutes)
- Alternatively could use prolonged service codes such as 99417 Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (Report in addition to codes 99205, 99215 for office or other outpatient E/M services.)

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Suture Removal: 15851, 15853, 15854

- Report 15851 only when suture and/or staple removal requires more than anxiolysis or local anesthesia
- Report either 15853 or 15854 for removal **in conjunction with an E/M service** in the office or other outpatient setting or ED, or in a patient's home or residential setting that occurs outside the global period of the related procedure
- Codes 15851, 15853, and 15854 may be reported when the service is performed by the same physician or QHP who performed the primary procedure or by another physician or QHP regardless of whether the performing physician or QHP is of the same specialty and/or group practice
- Unadjusted total non-facility RVUs represent only practice expense and professional liability insurance. **No work RVUs are assigned to these codes, as the associated E/M service captures the physician/QHP work associated with the decision for and/or supervision of removal of sutures and/or staples.**
- Report in conjunction with E/M or code S0630 (removal of sutures; by a physician other than the physician who originally closed the wound)

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The Challenge of Surge

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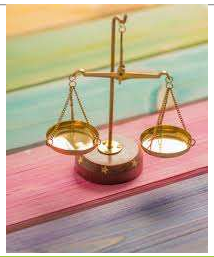
Balancing Act

- Serving the needs of patients and ALL families
- Providing right care, right place right time
- Avoiding inconsistent messaging



- Respecting practice team resource limitations
- Prioritizing practice team wellness
- Recognizing importance of the business implications of decisions

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Start with Right Care, Right Place, Right Time

- We should start with the mindset that our families **deserve** great care all the time
- We should accept the reality that we can't be the place to deliver that care all the time
- We should accept the reality that no matter how well we plan, there will be unexpected downtimes and unexpected surge
- We should accept the challenge that there are alternative ways to deliver care other than one patient at a time at face-to-face office visits
- We should accept the fact that we can't give every patient what they ***want*** (or what we want to deliver) 100% of the time but we should attempt to give them what they ***need***

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Consistency Matters

- Be very careful to not change "who gets seen" significantly based on slots in your schedule
- Follow evidence based guidelines where available
  - Cold/cough illnesses don't need to be seen with an office visit for every patient within the first day of symptoms
  - Don't "bring them in" because that's how you have always made money
  - Treat your patients like your own family…would you leave work to take your kid to the doctor's office for this reason today?
- Consistent messaging allows practice teams to act with confidence
- Consistent messaging allows families to set appropriate expectations

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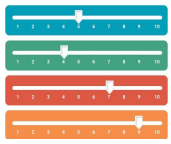
PLANNING to be Flexible

- Well visits remain the cornerstone of pediatric care
- Chronic care management and sick visits should be thought of like a "sliding scale"
- Practices should plan to both "beef up recalls" and "react to high sick demand"



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Partnerships Matter

- Understanding that we are not able to care for every patient according to best practices all the time
  - Identify alternate sites for care in your medical home neighborhood
  - Familiarize yourself with their hours, insurances, capabilities
  - Create helpful navigation tools for your practice team
- Form relationship with the entities who treat patients
- Set expectations with community partners about communications back to your office

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Messaging is Key!

- Educating patients about what constitutes "best practices/good care" sets appropriate expectations
- Empower patients to reach out to your practice if the care doesn't "seem appropriate" based on what you have taught them
- Provide clear and consistent messaging about the following:
  - When and how to reach out to medical home first before heading to other sources for episodic care
  - How to "keep their medical home informed" about care provided elsewhere
- Remember phone calls are the MOST expensive way to provide information to your families…consider alternatives
  - New patient onboarding coordinator and information
  - Website
  - Social media
  - Push messaging (emails, texts, newsletters)

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Empowering Families/Caregivers

- Give families appropriate tools to care for their ill children
  - Symptom checkers
  - Website information
  - Triage/phone nurses help families navigate BACK to trusted resources of information
- Be clear about when it is important to seek HEALTH care vs provide HOME care and TLC
- Ask families how else you could be meeting their needs

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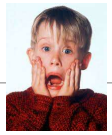
Scheduling Visits



- Be more flexible
- Consider having blocks that can be "adjusted" easily
- Schedule gaps that can be "used in times of surge" (such as the 50 minute hour)
- Consider "fast track" appointments (much like walk-ins, but needed for surge only)
  - Set very clear and limited expectations for these visits (*"this is a 5 minute appointment to be able to meet the needs of as many of our ill patients as possible during this period of heavy demand."*)
  - Be clear about what will and what will not happen at these appointments
  - Eliminate bottlenecks and hand offs to make these visits efficient (consider 1 provider/2-3 staff)
- Anchor your schedules with well visits
- Leave room for sick
- Flex visits for extra sick OR recall well/chronic disease

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Scheduling Providers

- Make a schedule with surge **protocols planned**
- Rotate the "fast track" time
  - If time not needed, use it for administrative "catch up time" or other administrative tasks
  - If time needed, give monetary rewards in addition to earned RVUs
  - Think of it like "on call" time in hospital nursing schedules
- Rotate "tacked on extra visits/extra hours"
  - Consider additional monetary incentives
  - Take in consideration different family demands and be flexible about "where" those tack on extra visits/hours occur (early, late, short lunch, etc.)
- Be realistic! You can never "create enough appointments" to see everyone.

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Streamlining Visits

- Consider adjusting well visits to "bare bones"
  - Doing developmental screening only at 9, 18 and 30 months
  - Ask about concerns re hearing/vision if they were done last year instead of testing everyone
  - May have to forego some of the surveys that you perform "ideally"
  - Start with Bright Futures request to prioritize "patient/family concerns" instead of your checklist
- Look for efficiencies in sick visits such as:
  - Text or portal message with lab results
  - Hand people or portal message with instructions
  - Set expectations for abbreviated visits
  - Self-scheduling
  - Eliminate unnecessary steps (immediately take to room, collect copay and check in in exam room)
  - Let people fill out forms for checking symptoms (or electronic surveys) in advance or at the visit
- Where do Telehealth visits fit in your offerings?
- Streamline all documentation!

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Meeting Community Needs

- Consider how to meet the needs of your community in different ways than office visits one by one
- FaceBook live educational segments/webinars
- Educational updates provided to your community
  - Push ***and*** pull distribution of information
- Partner with community organizations and other healthcare organizations to have large volume visit clinics (virtual OR in person)
  - Daycares/schools
  - Community centers
  - Religious organizations

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Please type your questions in the Chat box in the Zoom platform.

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Thank you for your participation.

An email with handouts and a link to the recording will be sent to all registered participants.

Please contact Noreen Dahill at ndahill@gaaap.org with any additional questions.

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