Taking Care of the Kids: Pediatric Risk Coding

Presented by:

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Ruth Mooney, CPC, CPMA, CRC

Natalie Eisenhower, CPC, CDEO, CPMA, CRC-I Approved Instructor

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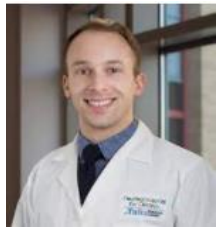
Today's Presenters



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Agenda

- Donna Campbell:
  - Introduction
  - Pediatric Risk Coding - Common Conditions and Tips
- Charles Hannum, MD:
  - Coding Tips from a Primary Care Pediatrician
  - Documenting and Coding Complex Patients for Accuracy in Risk Scores and E/M Levels
- Ruth Mooney:
  - Social Determinants of Health Coding Best Practices
- Natalie Eisenhower:
  - What Happens After You Document/Code Social Determinants of Health
- Questions?
- Appendix

Donna Campbell, CRC

- Introduction
- Pediatric Risk Coding – Common Conditions and Tips

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Introduction

- The Risk Coding Teams from Legacy NEQCA, Legacy Lowell General PHO and Tufts Medical Center are pleased to collaborate on this monthly educational series to review pertinent topics in Risk Adjustment Coding.
- Risk Adjustment Coding relates to the ICD-10 diagnosis codes for chronic conditions submitted on your claims. These codes drive the budgets assigned for the care of your patients in our Value-Based contracts, and must be submitted on claims at least once yearly.
- Our teams are involved in various risk adjustment coding activities, including pre-visit chart review, post-visit/pre-claims review, data evaluation and education, and we all see similar themes.
- During today's session, we will share our insights on pediatric risk coding and Social Determinants of Health, and Dr. Hannum will present some case studies for documentation and coding.
- We welcome your input and questions!

The Importance of Accurately Coding Your Pediatric Patients

- A pediatric chronic condition is a health problem that lasts more than three months while also affecting the child's normal activities and requires medical care and/or hospitalization(s).
- Children with chronic illnesses may be ill or well at any given time, but they are always living with their condition.
- In today's value-based world, chronic conditions are the driving force in determining healthcare outcomes and costs.
- Accurate ICD-10 diagnosis coding will help to set accurate budgets for the care of our pediatric patients.

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Quick Tips for Common Pediatric Conditions (See Appendix for Detailed Tip Sheets)

Asthma	If meds are being prescribed, be sure to document/code condition as current: — Ex: Asthma-stable on Symbicort
Depression	In the documentation, use terms that specify severity and/or clinical status: — Episode (single or recurrent) — Severity (mild, moderate, severe, with or without psychotic features) — Clinical status (in partial/full remission)
Obesity/Morbid Obesity	Document condition/plan in note, and remember to code for both BMI value and the condition.
Cancer	Cancer must be documented as current if you are using active cancer codes, otherwise select “History of” codes.
Drug Use/Dependency	Document and code for drug use/dependency when applicable.
Refilling Medications	Don’t forget to verify the condition and list the diagnosis in the Assessment and Plan.

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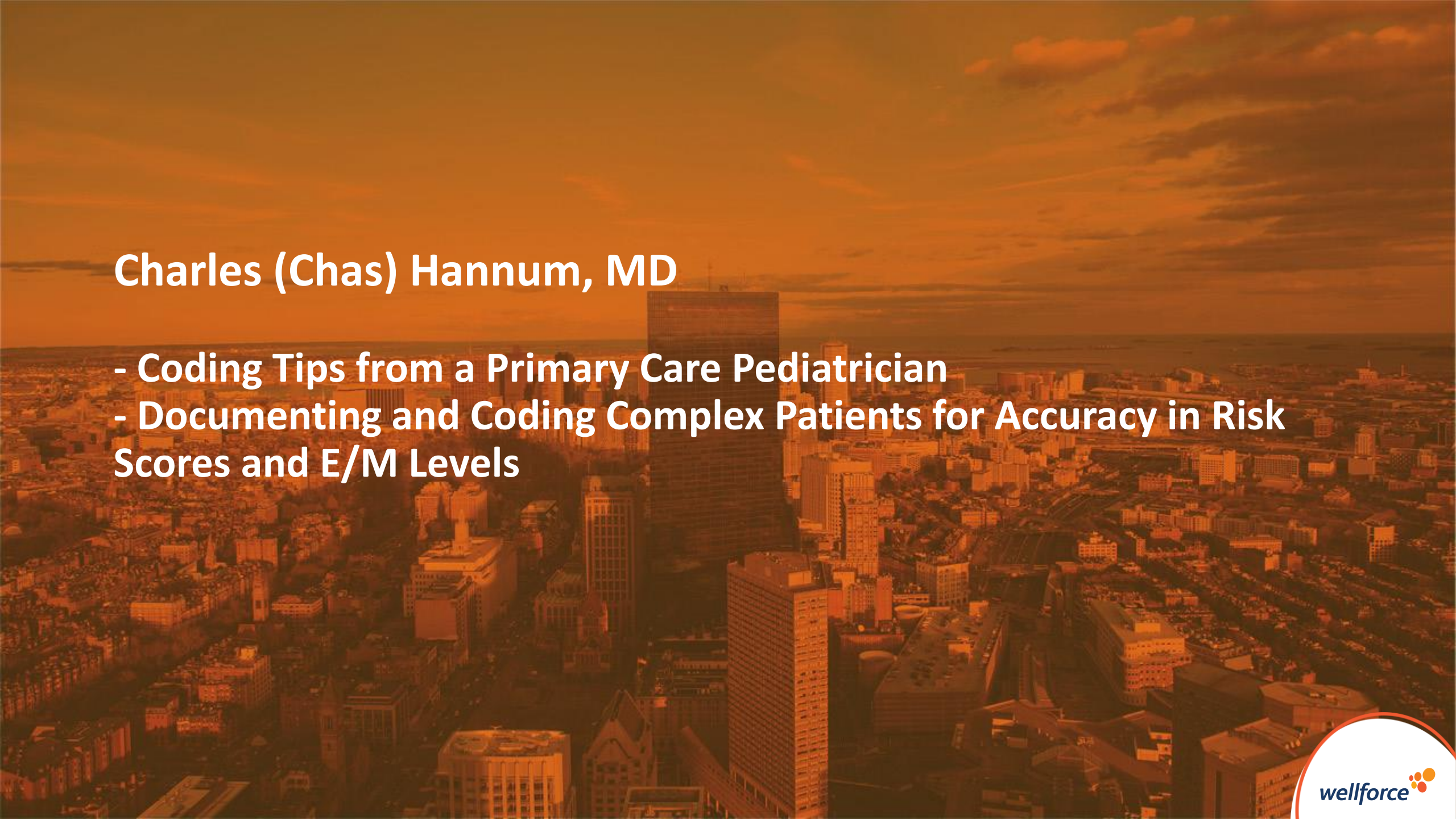
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Coding Tips from a Primary Care Pediatrician

- Annually, make sure to code:
  - Chronic problems/diagnoses, even though you may not be directly managing
    - Including DME status (i.e. g-tubes), prematurity (adds a level of complexity to patient), chronic diseases managed exclusively by sub-specialists (i.e. IBD)
  - Relevant family history
  - SDoH
- For chronic diseases you manage
  - If progressing/worsening or requiring a change in management/change in risk and/or additional work-up, you can likely bill a separate E/M for this during a physical
  - Additionally, significant time outside of routine well care can be billed
  - My mentality – “could this issue alone be billed as a visit?”

Chronic Disease example

- A patient with obesity presents for a physical:
  - Three typical outcomes
    - BMI is improving – time spent discussing/counseling *usually* looped into well care visit
    - BMI is stable – time spent discussing/counseling *usually* looped into well care visit
    - BMI is worsening (ie chronic disease is progressing)
      - *Time spent counseling/discussing might be significant enough to report separately*
      - *Complexity may also be a way to report separately*
        - A LOT of ways to get here…

2021 E/M Coding, Billing and Auditing Toolkit: E/M Quick Reference

MGMA

MEDICAL DECISION MAKING					
E/M code	**TIME** *(minutes)*	**MDM**	**Number and complexity of problems addressed**	**Amount and/or complexity of data to review and analyze** *(Combination of 2 or combination of 3 in Category 1)*	**Risk**
99202 99212	15-29 10-19	**Straightforward**	**Minimal** 1 minor prob	**Minimal or none**	**Minimal** Rest, gargles, bandages
99203 99213	30-44 20-29	**Low**	**Low** 2 minor prob 1 stable chronic ill 1 acute, uncomp ill/inj	**Limited** **Category 1: Tests and documents** Review or order tests **Category 2: Assessment requiring an independent historian(s)**	**Low** OTC drugs, minor surgery w/o risk factors, PT/OT, IV fluids w/o additives
99204 99214	45-59 30-39	**Moderate**	**Moderate** 1 or more chronic ill w/ exacerbation 2 or more stable chronic ill 1 undiagnosed new prob w/uncertain prognosis 1 acute illness w/syst symp 1 acute complicated inj	**Moderate** **Category 1: Tests, documents, or independent historian(s)** Review or order tests Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** Independent interp of a test performed by another provider **Category 3: Discussion of management or test interpretation** Discussion of mgmt or test interp w/external provider	**Moderate risk** Prescription drug mgmt, minor surgery w/ risk factors, decision for major surgery w/o risk factors, diag/trtmt significantly limited by SDoH
99205 99215	60-74 40-54	**High**	**High** •1 or more chronic illnesses w/severe exac-erbation • 1 acute or chronic ill/inj	**Extensive** **Category 1: Tests, documents, or independent historian(s)** Review or order tests Assessment requiring an independent historian(s) **Category 2: Independent interpretation of tests** Independent interp of a test performed by another provider **Category 3: Discussion of management or test interpretation** • Discussion of mgmt or test interp w/external provider	**High risk** Drug monitoring for toxicity, major surg w/risk factors, decision for em-rgncy surg, decision for hospitalization, decision DNR because of poor prognosis

PROLONGED SERVICES

(Must meet time components and 15 minutes or more. Each unit must reach 15 minutes to bill for prolonged services.)

99205	Each additional 15 minutes **after 74 minutes** on day of encounter	**Prolonged services codes** (add to appropriate E/M according to payer) **+99417 Commercial payers** **+G2212 Medicare**
99215	Each additional 15 minutes **after 54 minutes** on day of encounter	

TIME-BASED CODING ELEMENTS

*(When performed and documented. ****Time-based coding is based on total time spent on date of the encounter**)*

- Reviewing patient's record prior to visit
- Obtaining/review history from someone other than patient
- Performing a medically appropriate history and exam
- Counseling/educating the patient/family/caregiver
- Referring and communicating with another healthcare provider(s) when not separately reported during the visit
- Documenting clinical information in the patient's electronic health record
- Independently interpreting results
- Communicating results to the patient/family/caregiver
- Coordination of care for the patient
- Ordering prescription medications, tests, or procedures

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Obesity example

- How could we get to a 99214 E/M with an increasing BMI?
  - We already have a chronic illness that is progressing (Moderate complexity)
  - We need a moderate for data review or risk
    - Data review
      - *Ordering obesity labs and interpreting them (i.e. Hemoglobin A1c, lipids)*
      - *Reviewing nutrition note*
    - Risk
      - *BP is now elevated, hemoglobin A1c is increasing*
      - *SDoH provides significant limitations*
        - i.e. food insecurity, lack of access to safe physical activity opportunities

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Obesity example

- Time spent related to obesity care (independent on disease progression)
- Remember that this includes a LOT – review, documentation, counseling
  - If you spend **20** minutes doing motivational interviewing with a teenager related to obesity (ie stages of change, nutrition counseling, physical activity discussion) and **5** minutes documenting this conversation in the EMR
    - ***25*** *minutes =* ***99213*** *can be billed separately*
  - So if you spend **20** minutes doing motivational interviewing, **10** minutes counseling on nutrition, **8** minutes documenting these conversations, **5** minutes reviewing the chart for obesity-related care, and **5** minutes reviewing the labs you drew and calling family (same day)
    - ***48*** *minutes =* ***99215*** *can be billed separately*

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Complex Patient examples

Reason for Appointment

1. 9 year physical
2. Complex care patient
3. Interpreter # 760209

Assessments

1. Well child check - Z00.129 (Primary)
2. Dandruff in pediatric patient - L21.0
3. Encounter for immunization - Z23
4. Myopathy - G72.9
5. Weakness - R53.1
6. Neuromuscular respiratory weakness - J98.8
7. Neuropathy - G62.9
8. Wheel chair as ambulatory aid - Z99.3
9. Neuromuscular scoliosis of thoracolumbar region - M41.45
10. Constipation by delayed colonic transit - K59.01
11. Obstructive sleep apnea - G47.33
12. At risk for aspiration - Z91.89
13. Reactive airway disease - J45.909
14. Contracture of ankle and foot joint - M24.573
15. Chronic otitis media of both ears - H66.93
16. Dental caries - K02.9
17. Complex care coordination - Z71.89
18. Underweight - R63.6
19. Body mass index [BMI] pediatric, less than 5th percentile for age - Z68.51
20. Feeding difficulties - R63.3
21. Developmental delay - R62.50
22. Urinary incontinence due to immobility - R39.81
23. Frequent headaches - R51.9

Notes: I spent a total of 65 minutes with the family for this visit, with 45 minutes spent discussing acute concerns/issues as above outside of routine well care. I spent an additional 25 minutes in documentation review prior to the visit and in care coordination after the visit. Total additional physiain time: 70 minutes.

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Complex Patient examples

Reason for Appointment

1. Well child check, 4 years

Assessments

1. Well child check - Z00.129 (Primary)
2. Encounter for immunization - Z23
3. Premature infant of 34 weeks gestation - P07.37
4. Global developmental delay - F88
5. Autism - F84.0
6. Neurologic gait dysfunction - R26.9
7. Partial agenesis of corpus callosum - Q04.0
8. Polymicrogyria - Q04.3
9. Feeding difficulty in child - R63.3
10. Fine motor delay - F82
11. Constipation - K59.00
12. Stereotyped movements - F98.4
13. Language delay - F80.1
14. Failure to thrive in child - R62.51
15. Urinary incontinence due to cognitive impairment - R39.81

Notes: I spent 45 minutes addressing the medical problems above and discussing management, outside of routine well care, which included 20 minutes of visit prep/note and document review (genetics, CCSN, ENT, nutrition, GI, PMR/orthopedics), and 25 minutes in the room with the family and in coordinating care on the day of the visit with complex care.

[redacted] a young boy with multiple medical problems, including polymicrogyria, partial agenesis of the corpus callosum, autism and global developmental delay presents for a well visit. He continues to have persistent issues with development and is receiving special education services - he is making some progress, and it is nice to see him more active and engaging today! His oral aversion and feeding difficulties remain pronounced and some mild weight loss noted since March, but overall his trends are steady and BMI is in the healthy range. Routine immunizations given at a recent sick visit, so he is up-to-date on routine preventive care. He continues to be followed by multiple subspecialists. The family and [redacted] continue to receive exceptional support from the complex care team.

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- Social Determinants of Health Coding Best Practices

SDoH – Social Determinants of Health

- CMS defines social determinants of health as "*the range of social, environmental, and economic factors that can influence health status—conditions that can often have a greater impact on health outcomes than the actual delivery of health services*." The acknowledgment of these social, economic, and environmental issues is essential to providing value-based care.
- When the assessment and plan is developed with consideration of these social determinants of health, the documentation should clearly describe the circumstances and how they affect the patient's treatment or management.
- *SDoH* screenings are an integral part of a patient's visit
- Patient stated issues regarding *SDoH* are accepted and should be documented/coded
- Social history should be updated to reflect *SDoH* that affect the patient during that current visit
- *Example*: A patient requiring a specific drug that is very expensive, recently lost their job due to the COVID-19 pandemic, and has no income or prescription benefits. The decision might be made to try a different drug to ease the cost burden for the patient. (Z56.0 - Unemployment, unspecified)

Common Errors in Coding SDoH For Pediatrics

During a follow-up visit for the child, mom states that she recently lost her job, and is having a hard time with finances which is limiting what they can afford as a family.

- Z56.0 – Unemployment: The visit is for the child, and the child is not the one who is unemployed, the parent is. We would have to use a SDoH code to reflect the financial impact this is having on the child.
- Z59.8 – Other problems related to housing and economic circumstances

During a yearly physical, parents state that the family is been having a hard time adjusting during COVID, and there has been a lot of stress in the home.

- Often times providers do not code for these types of scenarios, but they document that the family is going through a stressful time.
- Z63.79 – Other stressful life events affecting family and household. SDoH codes are meant to capture socioeconomic factors that impact a patient's health. Family stress in children can lead to educational and emotion issues, that may warrant additional resources.

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- What Happens After You Document/Code Social Determinants of Health

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Importance of SDoH Documentation & Coding

- When an SDoH is identified, detailed documentation is useful for any handoffs to a referral or resource team
- Connects patients with needs to supportive services
- SDoH screenings are counted in some quality measures
- Helps to identify population-level trends that have both health & cost implications

Identify Needs

- Housing
- Food
- Transportation
- Employment
- Counselors
- Safety
- Social Supports

Beyond Documentation & Coding

During a follow-up visit for the child, mom states that she recently lost her job, and is having a hard time with finances which is limiting what they can afford as a family.

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- Z59.8 – Other problems related to housing and economic circumstances

Outreach & Support:

- Food
  - Food vouchers, help enrolling into SNAP (supplemental nutrition assistance programs), connect to local meal & food pantries, local farmers markets
- Financial assistance
  - Financial education (managing household budgets), credit building & repair, foreclosure prevention
  - Assistance with utilities or transportation

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Beyond Documentation & Coding cont.

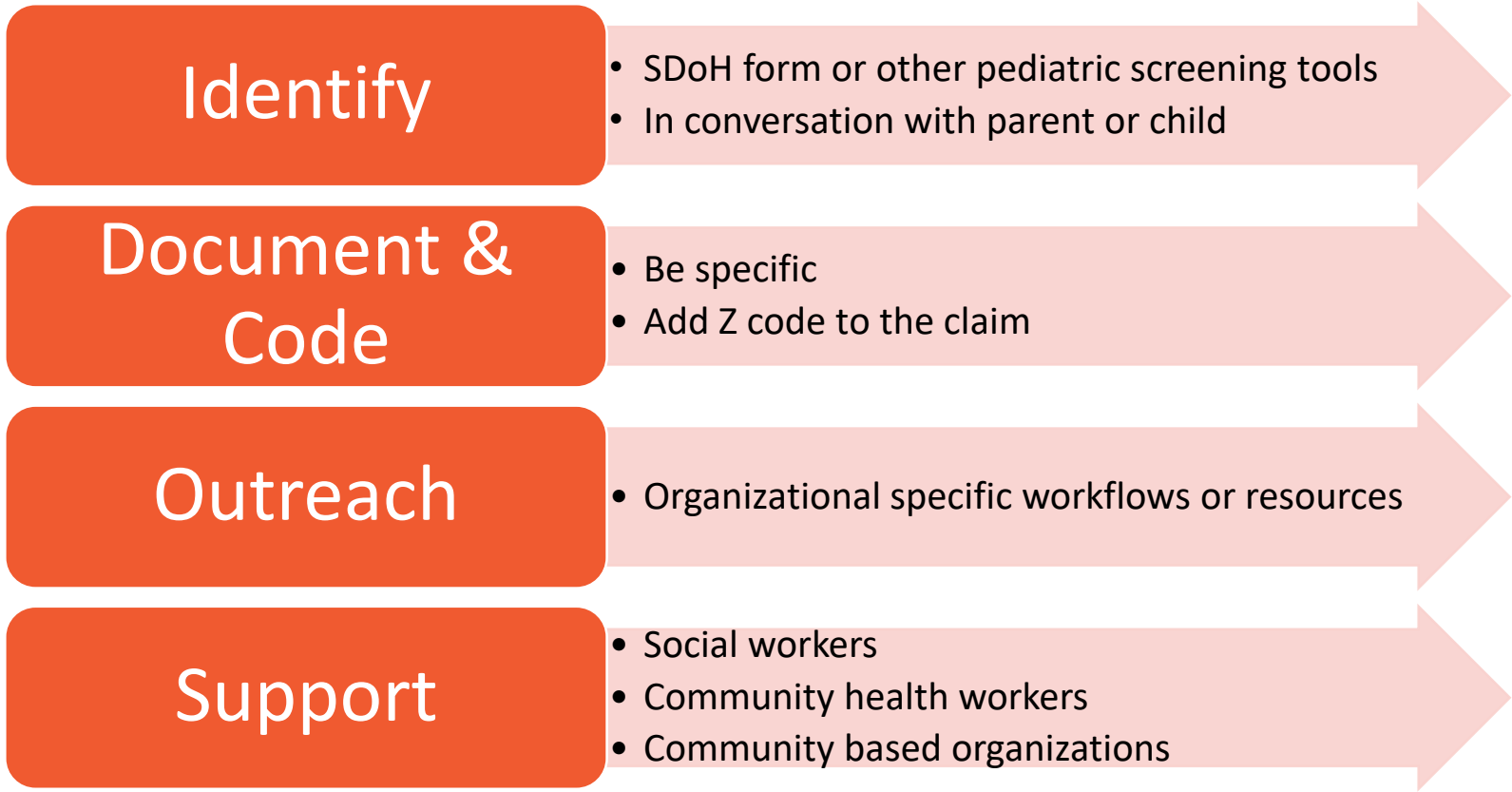
During a yearly physical, parents state that the family is been having a hard time adjusting during COVID, and there has been a lot of stress in the home.

- Often times provides do not code for these types of scenarios, but they document that the family is going through a stressful time.
- Z63.79 – Other stressful life events affecting family and household. SDoH codes are meant to capture socioeconomic factors that impact a patient's health. Family stress in children can lead to educational and emotion issues, that may warrant additional resources.

Outreach & Support:

- Community based organizations with structured programs for children or youth, after school or educational opportunities, career counseling or looking for work
- Substance abuse or treatment centers/assistance

Reminders



When needs are identified, better support can be offered to our patients

Thank You For Listening,
We Welcome Your Questions!

Appendix

- Asthma Coding Tips
- Documentation Tips for Depression Severity
- Coding for Pediatric Morbid Obesity, Obesity and BMI
- Cancer Coding Tips
- Commonly Used SDoH ICD-10 Codes

Asthma Codes J45.20 – J45.998

TIPS	Documentation Requirements
Specify in your documentation:	▪ Frequency (intermittent, persistent) ▪ Severity (mild, moderate, severe) ▪ Exacerbation or decompensation ▪ Environmental factors
Use additional codes to identify:	▪ Exposure to environmental tobacco smoke (Z77.22) ▪ Exposure to tobacco smoke in the perinatal period (P96.81) ▪ History of tobacco dependence (Z87.891) ▪ Tobacco dependence (F17.-) or Tobacco use (Z72.0)
Avoid using “history of” if patient is still being monitored for the condition	▪ Incorrect wording: Patient has history of asthma. ▪ Correct wording: Patient has asthma with no recent onset to exacerbation. Current medication includes albuterol inhaler

Documentation Tips: Depression Severity

- Severity and/or clinical status should be reported in HPI or A/P as:
  - Episode (single or recurrent)
  - Severity (mild, moderate, severe, with or without psychotic features)
  - Clinical status (in partial/full remission)
- If the depression is stable and patient does not currently meet MDD criteria, providers should document and code "in remission" status. *(Ex: F32.5 major depressive disorder, single episode, in full remission*). If patient is on medication and no longer having symptoms and PHQ-9 is negative because of that, we should code for partial/full remission.
- **Partial remission** is defined as absence of symptoms for less than two months or some symptoms present but not full criteria of major depression
- **Full remission** is defined as no significant signs/ symptoms of the disorder for at least two months. When reporting a history of major depressive disorder, assign a code from the mental disorders chapter with the fifth character for partial or full remission.
- An episode is considered recurrent when there is an interval of at least two consecutive months between separate episode during which criteria are not met for a major depressive episode

PHQ-9 total score	Depression severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Major depressive disorder:

- **F32.0** Major depressive disorder, single episode, mild
- **F32.1** Major depressive disorder, single episode, moderate
- **F32.2** Major depressive disorder, single episode, severe without psychotic features
- **F32.3** Major depressive disorder, single episode, severe with psychotic features
- *F32.9 Major depressive disorder, single episode, unspecified* (**F32.9 *DOES NOT RISK ADJUST***)

Recurrent major depression:

- **F33.0** Major depressive episode, recurrent, mild
- **F33.1** Major depressive episode, recurrent, moderate
- **F33.2** Major depressive episode, recurrent, severe without psychotic features
- **F33.3** Major depressive episode, recurrent, severe with psychotic features
- **F33.8** Other recurrent depressive disorders
- **F33.9** Major depressive disorder, recurrent, unspecified

Major depression in remission:

- **F32.4** Major depressive disorder, single episode, in partial remission
- **F32.5** Major depressive disorder, single episode, in full remission
- **F33.40** Major depressive disorder, recurrent, in remission, unspecified
- **F33.41** Major depressive disorder, recurrent, in partial remission
- **F33.42** Major depressive disorder, recurrent, in full remission

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Morbid Obesity/Obesity and BMI

BMI and Associated Weight Condition Pediatric ICD-10-CM	Documentation Specificity
<u>BMI Pediatric Values Z68.51- Z68.54 - Ages 2-19 (calculated by percentile)</u> 85th- 95th percentile = Overweight Equal to or greater than 95th percentile = Obesity 99th percentile or above = Morbid Obesity	• Treating provider must document obesity, morbid obesity, or weight associated condition within the note. • Document counseling for nutrition or physical activity is applicable. • Coders cannot infer a weight related diagnosis from a BMI value or percentage. • If BMI value does not match the weight associated condition, a coder cannot change the weight associated condition without clarification from the provider. (i.e. BMI = 45, but provider only documented that patient is obese.) • BMI should never be reported without a weight associated condition per ICD-10 CM guidelines

Cancer Coding Tips

TIPS	Documentation Requirements
➢ **Current Malignancy**	Documentation must show clear presence of current disease. ▪ Evidence of current/ongoing treatment • Chemotherapy • Radiation therapy • Suppressive therapy ▪ Physician/patient chose not to treat
➢ **Documentation Tips**	The following language supports actively monitoring condition and must be documented by the provider. In the documentation, mention: ▪ Medications reviewed and are current. ▪ If patient is seeing a specialist. ▪ Whether there has been any or no recent onset to exacerbation.
➢ **Active vs. Historical Cancer**	If documentation does not show clear evidence of active disease or treatment, malignancy is considered a “history of” for coding purposes (Z85.--). Cancer is considered historical when: ▪ The cancer was successfully treated and the patient isn’t receiving treatment. ▪ The cancer was excised or eradicated and there’s no evidence of recurrence, and further treatment is not needed. ▪ The patient had cancer and is returning for surveillance of recurrence. ▪ The patient is currently on adjuvant therapy for prophylactic purposes.

Commonly Used SDOH ICD-10 Codes

- Z55.0 Illiteracy and low-level literacy
- Z55.8 Other problems related to education and literacy
- Z55.9 Problems related to education and literacy, unspecified
- Z59.0 Homelessness
- Z59.1 Inadequate housing
- Z59.2 Discord with neighbors, lodgers and landlord
- Z59.3 Problems related to living in residential institution
- Z59.4 Lack of adequate food and safe drinking water
- Z59.5 Extreme poverty
- Z56.0 Unemployment
- Z56.9 Low income
- Z59.7 Insufficient social insurance and welfare support
- Z59.8 Other problems related to housing and economic circumstances (lack of transportation)
- Z59.9 Problem related to housing and economic circumstances, unspecified (utilities etc.)
- Z60.0 Problems of adjustment to life-cycle transitions
- Z60.2 Problems related to living alone
- Z60.3 Acculturation difficulty
- Z60.4 Social exclusion and rejection
- Z60.5 Target of (perceived) adverse discrimination and persecution
- Z60.8 Other problems related to social environment
- Z60.9 Problem related to social environment, unspecified
- Z63.0 Problems in relationship with spouse or partner
- Z63.31 Absence of family member due to military deployment
- Z63.32 Other absence of family member
- Z63.6 Dependent relative needing care at home
- Z63.72 Alcoholism and drug addiction in family
- Z63.79 Other stressful life events affecting family and household
- Z63.8 Other specified problems related to primary support group
- Z63.9 Problem related to primary support group, unspecified