School-Based Healthcare: 2024 Coding and Documentation

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This training is one of six funded by the Ohio Department of Health and developed in partnership with Nationwide Children's Hospital.

Objectives:

- Identify key aspects of telehealth, place of service, and credentialing.
- Discuss the changes to Evaluation and Management (E/M) Services.
- Understand how to code based on time.

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TELEHEALTH

- Consent with the patient/parent will be critical and identified location of the patient.
- Face to face with patient at least once a year.
- Clear limitations on what services are provided and the timing of these services (check the CPT code book as well as the specific third- party payment process.
- Review of insurance contracts for coverage and payment – and identified limitations.
- Secure audio and video with the patient “Not just face time” .
- Documentation process of services just the same as any service and modifier 95/GT.
- With the end of the PHE the Place of service is 02 unless specific insurance plans require the location of the patient (12 for home, 03 for school, etc.).

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PLACE OF SERVICE AND THE CARE YOU PROVIDE – WHERE IS CARE BEING PROVIDED?

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- The Place of Service can be challenging as not all insurance plans recognize certain places of service.
- 03 is technically a school, however if one has a defined office for the health care program that is part of an outside entity and for your use alone (and rent may be part of this) then POS 11 – Office is correct.
- 12 for Home visits.
- 13 for Assisted Living.
- 14 for Group Home.
- 15 Mobile Unit without a set “docking pad” maybe 11.
- 50 FQHC.
- 53 CMHC.
- 02 Telehealth at the end of the PHE.

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CREDENTIALING

- Provider credentialing in healthcare is the process by which medical organizations verify the credentials of healthcare providers to ensure they have the required licenses, certifications, and skills to properly care for patients.
- This process can be onerous and time consuming.
- CAQH process is standardized.
- Must have a valid license, malpractice, and is location specific.
- Needs to up updated yearly.

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E/M SERVICES (Evaluation & Management)

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- The changes that came about in 2021 for Office/Outpatient Care in 2023 were expanded for all E/M services throughout the care model.
- These changes reduce the documentation burden to focus from elements to medically indicated history and exam.
- There may be cases when a more complete history and exam is <u>required</u> by a third party (hospital, clearance process, or for administrative needs <u>but this does not impact the level of care.</u>

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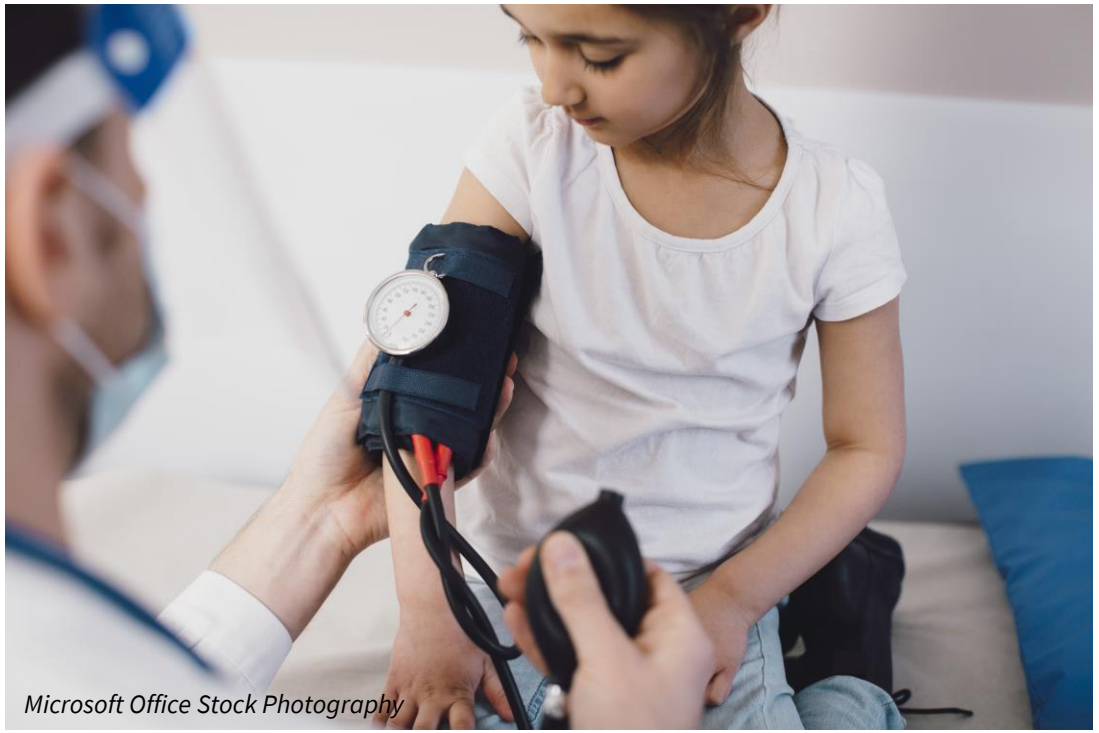
WHERE DOES PREVENTION OR WELL-CARE FIT



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- Prevention is age specific in coding.
- Prevention can only be provided once per year (by the primary physician) over the age of 7 years.
- Includes history, exam and anticipatory guidance.
- Orders or providers identified screening – lead, developmental, nutrition, exercise, etc.
- Creates a plan of care for chronic conditions.
- Can be coded with a condition E/M 99202-99215 based on medical decision making.

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PREVENTION DIAGNOSES CODES:

- Z00.110 Health examination for newborn under 8 days old.
- Z00.111 Health examination for newborn 8 to 28 days old.
- Z00.129 Encounter for routine child health examination without abnormal findings.
- Z00.121 Encounter for routine child health exam with abnormal findings.
- Z23 Encounter for immunization .

Screening codes (a few..)

Z13.31 Screening for depression.

Z13.39 Screening for other mental health issues.

Z13.1 Screening for diabetes.

Z11.1 Screening for TB.

Z13.49 Screening for other delays .

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PREVENTION CPT CODES:

- 9938 -- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient fifth digit based on age.
- 9939 -- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; fifth digit based on age.

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WHAT IS ANTICIPATORY GUIDANCE?

- Discussion of prevention measures by age and sex that would support a healthier lifestyle – diet, weight, exercise, taking medications, sleep hygiene, helmets, safe sex.
- Inclusion of age-appropriate screening and follow up care needs.
- Risk issues –seatbelts, SUD, abuse, hearing or vision, activity risk, social issues.
- Discussion about DNR (rare in the child population).
- Emergency plans based on chronic issues (asthma plan).
- Refill and status of chronic conditions – this can only be coded as an additional 9921x if there are issues, changes in care plan and a significant status issue.

- A template that covers all of these issues without specificity does not work!

SCREENING COUNSELING CODES THAT ARE CRITICAL FOR QUALITY CARE CODING

- 99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately **15** minutes.
- 99402 - 30 minutes.
- 99403 - 45 minutes.
- 99404 – 60 minutes.
- 99411 - Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately **30** minutes.
- 99412 – Group 60 minutes .
- Some of these things can be provided by specialists .

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THE DIAGNOSES FOR THESE SCREENING COUNSLEING SERVICES WOULD BE:

- In many cases the diagnoses for these prevention services would be the identified prevention Z codes or in cases when the counseling is to reduce or intervene before a condition becomes problems that condition.
  - Example of overweight (E66.3).
  - Prediabetes (R73.03).

- 99408 Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; **15** to **30** minutes (Z13.39 – screening for other mental health and behavioral conditions).
- 99409 – Greater than 30 minutes.

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THE SPECIFIC CPT E/M CODES AND THEIR REQUIREMENTS FOR DOCUMENTATION…

- The definitions transition to pertinent history, pertinent exam and medical decision making.

or

- Total time for the date of care in clinical activities for the patient (before, during and after face to face).

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HISTORY AND EXAMINATION IS NO LONGER THE DRIVING FORCE FOR A LEVEL OF CARE

- E/M codes that have levels of services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.
- There may be times from a clinical perspective that a complete history and exam is required – hospital requirements for admissions, pre-operative clearance, enrollment in home health, school exams for sports, etc.

DECISION TREE FOR NEW OR ESTABLISHED OFFICE/OUTPATIENT E/M CODING

Received any professional service from physician or other qualified health care professional in the same group or same specialty within the past 3 years?

Yes, Same <u>exact</u> Specialty or subspecialty

No

Yes, established patient

No – New patient

New Patient

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NEW VERSUS ESTABLISED PATIENT RULES—OFFICE SETTING/SCHOOL BASED SETTINGS:

- For the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.
- In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.

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THE LEVELS OF MEDICAL DECISION MAKING ACROSS ALL CODING:

- There are four types of medical decision making:

  1) **STRAIGHTFORWARD**; 2) **LOW**; 3) **MODERATE**; AND 4) **HIGH.**

- The 99211 and 99281 the level of MDM does not apply as these are services provided by support staff under the direct supervision of a physician or other qualified health care professional.
- **Medical Decision Making is defined by three elements**:
  - The number and complexity of the problems addressed during the encounter.
  - The amount and/or complexity of data to be reviewed and analyzed for the care of the patient.
  - The risk of complications and/or morbidity or mortality of patient management.

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NEW PATIENT E/M CODES (NOTE THE TIME CHANGES IN 2024):

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. **When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded**.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

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NEW PATIENT E/M CODES continued:

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

- (For services 75 minutes or longer, see Prolonged Services 99417/over 89 for the first unit of G2212).

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ESTABLISHED PATIENT E/M CODES (NOTE THE TIME CHANGES IN 2024):

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

ESTABLISHED PATIENT E/M CODES (NOTE THE TIME CHANGES IN 2024) continued:

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

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ESTABLISHED PATIENT E/M CODES (NOTE THE TIME CHANGES IN 2024) continued:

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

(For services 55 minutes or longer, see Prolonged Services 99417/ over 69 minutes G2212).

PROLONGED CARE SERVICES

- Code 99417 is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of office or other outpatient services, office consultation, or other outpatient evaluation and management services (ie, 99205, 99215, 99245, 99345, 99350, 99483).
- Prolonged total time is time that is 15 minutes beyond the time required to report the highest-level primary service. Codes 99417 are only used when the primary service has been selected using time alone as the basis and only after the time required to report the highest-level service has been exceeded by 15 minutes.


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THE VISIT


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- The components of the documentation should always clearly identify the issues pertinent to the care. This process reduces unnecessary documentation of “elements” just for documentation's sake – such as review of systems not pertinent to care or exam elements that are not relevant to the treatment needs and plan.
- The focus is on the problems addressed.
- Amount and/or complexity of the data to be reviewed and analyzed specific to the encounter/visit.
- Risk of complications and/or morbidity or mortality of patient management specifically stated within the note.

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E/M CARE STARTs WITH THE “PROBLEM”

- The presenting problem (reason for the visit or care) not just from the EMR listing.
- The problems addressed – and actively managed and considered in the care plan.
- Diagnoses involved in care with the status, impact for treatment and outcome issues.
- Data that is used in diagnoses and treatment.
- Identified risk issues with specific condition being treated, secondary diagnoses impacting the care plan and psycho-social issues that may alter the plan.

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THE 12 E/M PROBLEM LEVELS:

- Minimal problem (nursing level of care).
- Self limited or minor problem.
- Stable, chronic illness (something at least 12 months in duration).
- Acute, uncomplicated illness/injury.
- Acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care.
- Stable, acute illness.
- Chronic illness w/exacerbation, progression, side effects.
- Undiagnosed new problem with uncertain diagnoses – that can cause major medical issues.
- Acute illness with systemic symptoms.
- Acute complicated injury .
- Chronic illness w/severe exacerbation, progression or side effects of treatment.
- Acute or chronic illness or injury that poses threat to life or body function.

MINIMAL PROBLEM

- **Minimal problem**: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).◀

- Weight check, medication review, nurse education.

SELF LIMITED OR MINOR PROBLEM

- **Self-limited or minor problem**: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

- Wart without treatment, condition without treatment (rash, OTC care).

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STABLE, CHRONIC ILLNESS

- **Stable, chronic illness*:*** A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.
- Asthma, ADHD, obesity/weight issues, GERD, sleep issues.

ACUTE, UNCOMPLICATED ILLNESS OR INJURY

- **Acute, uncomplicated illness or injury:** A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

- Otitis media, strep throat, sprained ankle, simple foreign body, simple laceration, conjunctivitis.

ACUTE, UNCOMPLICATED ILLNESS OR INJURY REQUIRING HOSPITAL INPATIENT OR OBSERVATION LEVEL OF CARE

- **Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care:** A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

- Head trauma, asthma with exacerbation, RSV, dehydration.

STABLE, ACUTE ILLNESS

- **Stable, acute illness:** A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.

- Non resolving otitis media, bronchiolitis, cellulitis.

CHRONIC ILLNESS, WITH EXACERBATION, PROGRESSION, OR SIDE EFFECT OF TREATMENT

- **Chronic illness, with exacerbation, progression, or side effects of treatment:** A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

- Asthma in poor control, ADHD with complications, acne with complications of medication.

UNDIAGNOSED NEW PROBLEM WITH UNCERTAIN PROGNOSES

- **Undiagnosed new problem with uncertain prognosis:** A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

- Possible acute appendicitis, mass of uncertain etiology, lab work identifying major concern with need for referral.

ACUTE ILLNESS WITH SYSTEMIC SYMPTOMS

- **Acute illness with systemic symptoms:** An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

- RSV, COVID, Gastritis.

ACUTE, COMPLICATED INJURY

- **Acute, complicated injury:** An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

- Open fracture, burn, trauma, suspected abuse, playground injury.

CHRONIC ILLNESS WITH SEVERE EXACERBATION, PROGRESSION, OR SIDE EFFECT OF TREATMENT

- **Chronic illness with severe exacerbation, progression, or side effects of treatment:** The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

- Hospitalized Asthma, Crohn's disease, side effect of a medication requiring intervention.

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ACUTE OR CHRONIC ILLNESS OR INJURY THAT POSES A THREAT TO LIFE OR BODILY FUNCTION

- **Acute or chronic illness or injury that poses a threat to life or bodily function:** An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.

- This would include BH/SUD issues as well as medical.

THE GRID FOR LEVEL OF PROBLEMS IS…

CPT by POS	Level of MDM	Number and Complexity of Problems Addressed at the Encounter
99202 99212	Straight-forward	Minimal - One self limited or minor problem
99203 99213	Low	• Two or more self-limited or minor problems or, • One stable chronic illness or, • One acute, uncomplicated illness or injury. • One stable acute illness. • One acute uncomplicated illness/injury requiring hospital inpatient or observation level of care.
99204 99214	Moderate	• One or more chronic illnesses with exacerbation, progression, or side effects of treatment or, • Two or more stable chronic illnesses or, • One undiagnosed new problem with uncertain prognoses or, • One acute illness with systemic symptoms or, • One acute complicated injury.
99215 99205	High	• One or more chronic illnesses with exacerbation, progression, or side effects of treatment with consideration of inpatient care or, • One acute or chronic illness or injury that poses a threat to life or bodily function.

THE DATA IS DEFINED IN A NUMBER OF WAYS IN 2024

- The amount and complexity of data to be reviewed and analyzed is broken down into categories. These are the informational components used in this encounter for the care plan.

- On the next slide are the specific category levels by CPT code and then the review of the specifics for these categories as it relates to addiction and psychiatric care.

- Data is counted based on each and every individual source used in the care process.

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DATA LEVELS

Level of MDM	Data Components
Straight-forward	Minimal or none
Low – Limited at least one of these two categories	**Category 1: Tests and documents** **Any combination of two from the following:** Review of prior external note(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
Moderate **Must meet the requirement of at least one of the three categories**	**Category 1: Tests, documents, or independent historian(s)** **Any combination of three from the following**: Review of prior external note(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test*; Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)

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DATA LEVEL FOR HIGH LEVEL

Level of MDM	Data Components
High **Extensive must meet requirements of at least two of three categories**	**Category 1: Tests, documents, or independent historian(s)** **Any combination of three from the following**: Review of prior external note(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test*; Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** **Or** **Category 3: Discussion of management or test interpretation** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

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RISK BY LEVEL OF CARE

Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	NA
Low	Minimal risk of morbidity from additional diagnostic testing or treatment
Moderate	Moderate risk of morbidity from additional diagnostic testing or treatment. Examples only: • Prescription drug management. • Decision regarding minor surgery with identified patient or procedure risk factors. • Decision regarding elective major surgery without identified patient or procedure risk factors. • Diagnosis or treatment significantly limited by social determinants of health.
High	High risk of morbidity from additional diagnostic testing or treatment. Examples only: • Drug therapy requiring intensive monitoring for toxicity. • Decision regarding elective major surgery with identified patient or procedure risk factors. • Decision regarding emergency major surgery. • Decision regarding hospitalization or escalation of hospital-level care. • Decision not to resuscitate or to de-escalate care because of poor prognosis. • Parenteral controlled substances.

HOW IS RISK DEFINED IN THESE CHANGES

- Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter. Risk defined for a condition may be similar to treatment risk but is part of this overall process.

COMPONENTS RELATED TO RISK

- Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.
- Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.
- Surgery (minor or major, elective, emergency, procedure or patient risk):
  - Surgery—Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.
  - Surgery—Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient’s condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
  - Surgery—Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

HOW DO WE DOCUMENT PRESCRIPTION MEDICATION MANAGEMENT:

Medication	How to use	Use and Side Effects	Monitoring Needs
Amoxicillin - antibiotic	Taken as directed (often 2x per day or 3x per day)	Use to treat infections like strep, ear infections, sinus – side effects may include nausea, diarrhea or headache	None – but take as directed
Zyrtec	Taken once a day in the morning 30 minutes prior to eating	This medication reduces treats and manages asthma symptoms, season allergies and year-round allergies – side effects include drowsiness	None – but take as directed and see provider regularly for ongoing assessment of condition
Concerta	The timing of this medication should be determined with the provider for best response	This medication is used to treat and manage ADHD and has side effects related to sleep, diet, chest pain and behavioral issues	Monitoring of ADHD with regular provider visits and assessment , this is a controlled medication

CODING BY TIME

- When time is the driver of care for the level of CPT code time must be documented.
- When the time extends into prolonged care this process must reflect the acuity of care needs with the time documented.
- The time for care must make common sense.

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TIME AS THE FACTOR IN CODING OF CARE

- When time is the driver of care for office/outpatient E/M services this time will includes:
  - Pre-visit preparing to see and care for the patient – review of records, calls, reports.
  - Time face-to-face with the patient.
  - Time throughout the day of the visit involved in direct patient care (orders, discussion, review, etc.).
  - Unique documentation (ISP, care plans, goals/objectives, etc.).
  - Specific time for each level of care is identified within the CPT code definition and is the minimum amount of time for care.
  - Additional coding is available for prolonged care and is only added to the highest level of E/M codes – 99205 for new patients and 99215 for established patients.

DETERMINING THE CORRECT PROLONGED CARE CODE TO USE IN AN OUTPATIENT/SCHOOL SETTING:

TYPE OF CONTACT	CODING	TIMING
None face to face on a non patient care day.	99358 Prolonged evaluation and management service before and/or after direct patient care; first hour ✚ 99359 each additional 30 minutes (List separately in addition to code for prolonged service)	At minimum 31 minutes of activity and would include review of documentation, contact with patient/family or others. Not to be confused with telephone or telehealth services
Additional time on a date of care outpatient/office or patient home/residence setting	99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)	(Use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483 (Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416) (Do not report 99417 for any time unit less than 15 minutes)

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THE SOCIAL DETERMINANTS OF HEALTH OFTEN DEFINE THE CARE PROVIDED AND ARE CRITICAL IN 2024

Office of Disease Prevention and Health Promotion
US Department of Health and Human Services

- In 2021 the E/M coding identified Social Determinants of Health (SDOH) as a component for office and outpatient levels of care.
- This process is part of the quality improvement as well as cost management for the overall health care system.
- These 5 area can be reflected in ICD 10 codes that are identified within Chapter 21 of the ICD 10 text cover lifestyle, social environment, upbringing, support and family circumstances, legal issues and compliance. In the Z code section are also codes related to family history and personal history of conditions that may impact overall risk.

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CODES PERTINENT TO PSYCHOSOCIAL DETERMINANTS OF HEALTH…

These codes that are common for the psychosocial determinants of health are in the following families of ICD 10 codes…

- **Z55** – school and education issues.
- **Z59** series with home setting – home insecurity, food issues, etc.
- **Z60** series with social environment – bullying, social exclusion.
- **Z62** series with upbringing issues – foster care, adopted, sibling issues.
- **Z63** problems with support group and family circumstances – family member death, disruption.
- **Z65** problems related to legal and related issues.
- **Z51.81** medication monitoring – and added **Z79.899** if high risk medication.
- **Z91** compliance issues.

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HISTORY CODES THAT MAY IMPACT CARE

- History of bariatric surgery Z98.94 Bariatric surgery status.
- History of cancers: Z85. - - family of codes.
- Family History: Z80. - - family of codes.
  - Z80.3 family history of diabetes.
  - Z82.- - family history of chronic issues.
- Medication issues: Z51.81 Encounter for therapeutic drug level monitoring.
- Noncompliance : Z91. - - family of codes.
- Dependence on Z99.3 Wheelchair; Z99.81 Oxygen dependence.

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THINKING ABOUT THE DOCUMENTATION OF CARE IN ANY LOCATION – AND HOW IT IS BILLED…

- Always identify the specific problem(s) and their status.
- Pertinent history and exam, and a more complete history exam when required, remembering these elements do not change a level of E/M coding.
- Identified assessment with status, risk and assessment.
- Orders and plan.
- Any secondary problems impacting the care plan.
- Signed and dated.

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NEW CODES IN 2024 TO BE AWARE OF:

Based on your role with the children you see in clinic in 2024 there are new codes available to include caregiver support and principal care management. These codes may or may not be covered by Medicaid and commercial insurance but reflect some of the care provided:

- Caregiver support and education in a group setting (CPT codes 96202 and 96203).
- Caregiver training with direct involvement of parents/guardians (CPT codes 97550, 97551 and 97552).
- Principle Care Management of a single high-risk condition by the provider who is involved ongoing care and management (CPT codes 99424, 99425, 99426 and 99427).

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FINAL THOUGHTS

- If the care and services are not documented, they are considered not performed.
- Timely for documentation and claim submission.
- Complete within EMR/EHR or handwritten document.
- Signed and dated.
- HIPAA compliant.

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Thank You

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