Physician Payment in a Medical Home

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Children with special healthcare needs represent about 15% of most primary care pediatricians’ practices, but that number of children and young adults utilizes the time and resources of practitioners to a disproportionate extent. These patients require physician time that is frequently under-reimbursed, including time spent in the office and on the telephone, time dedicated to communication with pediatric subspecialists, and review of correspondence from schools, therapists, insurance companies, and home health agencies.

There are, however, several steps the primary care practitioner can employ to maximize reimbursement, including time-based billing, prolonged service codes, and billing for developing and implementing care plans.

General Strategies for Billing

Common Procedural Terminology (CPT) Evaluation and Management (E and M) codes are intended to measure the value of clinical work. Specifically, E and M codes measure the level of provider work by weighing all pertinent medical findings documented in the history and physical examination sections of the medical record in combination with the assessment of complexities and the risks of diagnoses and treatment. The selected E and M code is based upon documentation of three components: level of history, examination, and decision-making. In the case...
of a child with a fever, the E and M code is chosen based on how many elements of history and examination are related to the complexity of decision-making of the diagnosis.

The level of coding must also reflect the severity or complexity of a problem. For example, a diagnosis of otitis media would not support a more complex 99215 code, but chronic otitis media with mastoid involvement would be appropriate for a diagnosis of higher complexity. Higher coding levels may be determined by increased complexity of decision-making, such as a complex diagnosis or management question. Another factor involved in determining a code is level of risk. A decision about whether surgery is indicated for a specific condition, for example, may be classified as a higher risk discussion and warrant a higher code visit.

The best way to describe CPT is a description of the service provided, whereas the International Classification of Disease (ICD) code describes the level of medical neediness. It catalogues the diagnosis, symptoms, problem or complaint brought to the physician.

TIME-BASED BILLING
Caring for children with special healthcare needs often requires additional time to counsel patients on care plans and to coordinate care. When more than 50% of office visit time is spent in counseling or care coordination, providers can use time-based billing, which, in many cases, may allow them to bill at a higher level. Take, for example, a visit with a child who has Down syndrome and a fever. While the physician examines the child and takes a history, he also spends 15 minutes of the 25-minute visit discussing the child’s development and a recent visit with a subspecialist. In this case, the dominant criterion is time and the visit may be coded as 99214 for counseling. It is important to note that the chart must reflect documentation of the time spent in counseling the family members. The documentation might be as follows: “15 of the 25 minutes in visit was spent in discussion with the parent about recent neurologist visit and medication changes.”

The time-based codes that can be used include:
99214: 13 or more of 25 minutes used for counseling
99215: 21 or more of 40 minutes used for counseling

USE OF THE -25 MODIFIER
A well-child or preventive visit for a child with special healthcare needs may also involve lengthy discussions with the family regarding the child’s condition. If the child presents with a new separate and distinct condition during the visit, such as a fever, it is possible to bill for the well child visit and for a sick visit using the -25 modifier.

You can bill first for the preventive visit and bill for the new condition as well. If you document the presenting symptoms and treatment apart from the preventive visit on a separate document, you may use a -25 modifier along with a standard CPT code, such as 99213-5, and the ICD-9 diagnosis code for fever.

PROLONGED SERVICE CODES
An alternative to the use of a -25 modifier, especially when a great length of time is involved or the issue presents during a sick or problem visit, is to bill for time as a prolonged service code. Each E and M code is designated a usual service duration. For example, the usual service duration for code 99213 is 15 minutes. If the visit time exceeds the usual duration by at least 30 minutes, prolonged service codes may be used to bill for additional time.

When outpatient face-to-face care is prolonged beyond what is usual for the CPT code, the following codes may be used in conjunction with the usual office visit code:
99354: 30-74 minutes additional face-to-face time
99355: each additional 1-29 minutes (use in conjunction with 99354)

A child is seen for evaluation of a respiratory illness. In the course of the visit, a parent raises concerns about the child’s behavior and sleep. A 40-minute discussion follows. Because the concern raised by the parent is a separate identifiable issue, the use of a prolonged service code is an appropriate means of coding.

When prolonged service time involves non-face-to-face-time, such as reviewing records, communicating with specialists, the following CPT codes may be used in conjunction with the usual office visit code:
99358: 30-74 minutes additional non-face-to-face time
99359: each additional 1-29 minutes (use in conjunction with 99354)

CONSULTATION CODES
Children with special healthcare needs often require surgical procedures, and the primary care physician may be asked to evaluate the child’s overall health before the procedure takes place. In other cases, a physician with particular expertise may be asked by another physician to evaluate a child’s specific problem or recommend care strategies. Consultation codes, which typically reimburse at higher levels than corresponding office visit codes, may be used in such situations.

In billing, a consultation is defined as a type of evaluation and management service provided by a physician whose opinion or advice regarding the management and evaluation of a specific problem is requested by another physician or other appropriate source. A consultation is also used to recommend care for a specific problem or condition to determine whether to accept respon-
sibility for ongoing management of the patient’s entire care or for the care of a specific problem. Documentation of a consultation should include language that indicates that the visit was requested by a specific individual and for a specific condition.

99241: Office or other outpatient consultation, new or established patient; self-limited or minor problem, 15 minutes
99242: Low-severity problem, 30 minutes
99243: Moderate-severity problem, 45 minutes
99244: Moderate- to high-severity problem, 60 minutes
99245: Moderate- to high-severity problem, 80 minutes

BILLING FOR CARE PLAN DEVELOPMENT AND OVERSIGHT

A medical home addresses the needs of children with chronic health conditions by coordinating the care provided by the primary care physician, pediatric subspecialists, and pediatric therapists. Coordination of care is facilitated by effective communication between various healthcare providers, which requires efficient record keeping and the frequent review of health information, especially when that flow of communication is bidirectional. This type of communication is essential to addressing the concerns of families who depend upon the primary care physician to direct care in the context of a medical home.

Specifically, children with special healthcare needs, their families, physicians, and community providers will all communicate better and benefit from having a clear, written medical summary, emergency treatment plan, and plan of care in written or electronic format. The first step is to consult with the family to assess the needs of the child. After identifying the needs, a plan of care is developed with the family and goals and outcomes discussed. A care coordinator, when available, may clarify with the family which action steps the family will address and which will be addressed by the care coordinator and the practitioner. The purpose of these plans is to provide:

[Image]

If the visit time exceeds the usual duration by at least 30 minutes, prolonged service codes may be used to bill for additional time.

These codes may be used when the patient is not present, and therefore are useful for services, such as paperwork and phone calls. Most physicians will find it useful to have a worksheet or log to keep track of individual encounters and report for payment monthly.

The appropriate codes include:

99339: Individual physician supervision of a patient (patient not present) in home, domiciliary, or rest home (eg, assisted-living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with healthcare professional(s), family member(s), surrogate decision-maker(s) (eg, legal guardian), and/or key caregiver(s) involved in patient’s care, integration of new information into the medical treatment plan, and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.
99340: Same as 99339, but 30 minutes or more

Do not report 99339 or 99340 for patients under the care of a home health agency, enrolled in a hospice program, or for nursing facility residents. The following codes are used when providing care plan oversight when a patient is in home care, hospice care, or resides in a skilled nursing facility:

99341: Same as 99339, but 30 minutes or more
99374: Home care when patient under the care of home health agency, 15-29 minutes
99375: Home care when patient under the care of home health agency, more than 30 minutes
99377: Hospice care, 15-29 minutes
99378: Hospice care, more than 30 minutes
99379: Nursing home, 15-29 minutes
99380: Nursing home, more than 30 minutes

1. A source of information for family members and other health providers;
2. An emergency reference form with up-to-date information specific to the child; and
3. An action plan that identifies priorities and specific actions to implement tasks.

The care plan oversight codes are intended to report services for children with special healthcare needs and chronic medical conditions provided by primary care physicians who coordinate the medical care management with other medical and non-medical service providers and the family. The codes may encompass oversight of work or school programs when therapy, such as physical or occupational therapy, is provided.
TEAM CONFERENCES

Physicians may participate in conferences with a multidisciplinary team of professionals. An example is physician attendance at an Individualized Education Program (IEP) meeting. Physicians may bill for such time using the following codes:

99366: Medical team conference with interdisciplinary team of healthcare professionals, face-to-face with patient and/or family, 30 minutes or more, with participation by a non-physician qualified healthcare professional.

99368: Medical team conference with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more, with participation by a non-physician qualified healthcare professional.

PREVENTION AND EDUCATION

In some cases, children with special healthcare needs may benefit from preventive counseling services. The following codes are appropriate for individual counseling:

99401: Preventive medicine counseling and/or risk factor reduction provided to an individual that should address issues, such as family problems, diet, and exercise, substance abuse, injury prevention, and diagnostic and lab results, 15 minutes. Not for reporting counseling or risk-factor reduction provided to patients with symptoms or established illnesses.

99402: Same as 99401 but 30 minutes
99403: Same as 99401 but 45 minutes
99404: Same as 99401 but 60 minutes

When parents were asked about the role of a community physician in the care of children with special needs, their highest priorities for involvement were the following: information on community resources, financial information and assistance, and parent support groups. These interests may be discussed in a group visit conducted by the physician. Some practices have utilized condition specific support groups, such as for families with children with autism spectrum disorder. This may be an opportunity to include practice staff as well as outside therapists for the discussions. See Sidebar 1 for information on coding.

IMPLEMENTING PRACTICE CHANGE

Some of the codes discussed in this article, such as prolonged service codes, may be inconsistently reimbursed by payers. It is important to code for services provided, even if not reimbursed, to generate a record to justify future reimbursement. Contract negotiations with payers provide opportunities to secure reimbursement for codes relevant to children with special healthcare needs. Some practices have successfully obtained payment for codes simply by making a request for payment. The American Academy of Pediatrics (AAP) advocates for appropriate medical home reimbursement (see Sidebar 2).

CONCLUSIONS

In any primary care practice, a key obstacle to obtaining appropriate payment for the services that are provided is getting providers to change their billing practices. Because the financial revenue of pediatric practices is based on E and M codes rather than procedures, it is important that practitioners be knowledgeable about the effect of how patients are billed for services.

To start, most practices designate one physician to work with office staff, including the practice manager, to do a periodic assessment of the coding. Many practices employ or designate one employee as a “coding specialist” to track which codes are being paid appropriately. When specific codes are denied, the denials may be tracked for possible appeal. Practitioners may use the AAP’s Private Payer Advocacy Advisory Committee as a resource for payment issues.
The practice should have a baseline understanding of how the practice’s physicians individually code. In most practices, if one plots the typical E and M codes using a bell shape curve, one finds a predominance of 99213 codes. However, because most pediatric offices provide care for a larger proportion of children and youth with special healthcare needs, the curve should be shifted to the right, with a higher number of 99214 and 99215 codes.

When one pediatric practice in South Carolina evaluated their coding, they determined a baseline of physician performance, and then undertook an education program within the practice. This program mainly provided comparative data to the practitioners. They also hired a coding specialist to conduct chart audits. When assessed after 5 years, there was an increase in revenue of more than $40,000 per year per physician. Most of the increase in revenue resulted from a greater number of visits coded using time-based billing, an increase of code 99214 from 5% to 26% of the total visits. The effect of having a physician leader and coding consultant, along with comparative data, was remarkable. Indeed, most studies of changing physician behavior cite the use of comparison as the most effective means of generating practice change. With a little effort you, too, can work smarter rather than working harder.

REFERENCES