Medication Therapy Management Services: Clinical Documentation - Using a Structured Coding System
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CPE Information

• Target Audience: Pharmacists & Technicians
• ACPE#: 0202-0000-15-208-L04-P/T
• Activity Type: Application-based

Pharmacist Learning Objectives

• Define relative value units (RVUs) and describe the impact of E&M and procedure codes on RVU generation.
• Discuss the Centers for Medicare and Medicaid Services (CMS) reimbursement for medication therapy management (MTM) services.

Pharmacy Technician Learning Objectives

• Discuss documentation requirements for problem focused (PF), expanded PF, detailed, and comprehensive patient care encounters.
• Define relative value units (RVUs) and describe the impact of E&M and procedure codes on RVU generation.
• Discuss CMS reimbursement for MTM services.
• State role of pharmacy technician in coding of patient encounters.
Self-Assessment Question 1
Which components of documentation are required for a comprehensive patient care encounter?
A. Chief Complaint, Extended History of Present Illness, Complete Review of Systems, Complete Past, Family, and/or Social History
B. Chief Complaint, Brief History of Present Illness
C. Chief Complaint, Brief History of Present Illness, Problem Pertinent Review of Systems
D. Chief Complaint, Extended History of Present Illness, Extended Review of Systems, Pertinent Past, Family, and/or Social History

Self-Assessment Question 2
Which of the following E&M codes is not appropriate for documenting a clinical pharmacist encounter?
A. 99363 – Anticoagulation mgmt, subsequent 90 days
B. 99499 – Unlisted E&M Code
C. 99443 – Telephone E&M Service; 21-30 minutes
D. 99205 – OFF/OP VST, New: Comp, MOD-HI, 60M

Self-Assessment Question 3
Which of the following procedure codes are for performance measurement documentation and do not contribute to RVU generation?
A. CPT® Category II Codes
B. Level I (CPT®) Codes
C. Level II HCPCS Codes
D. None of the Above

Self-Assessment Question 4
Pharmacy technicians can help the clinical pharmacist document patient encounters in AHLTA and positively impact encounter coding
A. True
B. False

Medical Record Documentation
• Medical Record Documentation Facilitates:
  – Ability to evaluate and plan treatment
  – Communication and continuity of care
  – Accurate workload and productivity credit
  – Appropriate utilization review and quality of care evaluations
  – Collection of data useful for decision support, research, population health, and education

Appointment Types
• SPEC: Initial appointment to a specialist
• OPAC: Care required within 24 hours
• FTR: Non-urgent services beyond 24 hours
• GRP: Therapy, counseling, or teaching sessions in a group setting
• T-CON: Unscheduled telephone service
**New vs. Established Patients**

- **New Patient**
  - One who has not received any professional services from the privileged provider or a provider of the exact same specialty and subspecialty who belongs to the same group practice in the previous three years
  - The reason for the initial subspecialty encounter must be documented

- **Established Patient**
  - One who has received professional services from the provider or another provider of the exact same specialty and subspecialty who belongs to the same group practice in the previous three years
  - A common error in DoD is a provider new to the facility coding all patients as new
  - The patients who had been seen in the clinic by the previous provider or group in the prior three years are all established patients to that clinic

**Patient Care Encounters**

<table>
<thead>
<tr>
<th>Type of History</th>
<th>Chief Complaint</th>
<th>History of Present Illness</th>
<th>Review of Systems</th>
<th>Past, Family, and/or Social History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Required</td>
<td>Brief</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Expanded</td>
<td>Required</td>
<td>Brief</td>
<td>Problem Pertinent</td>
<td>NA</td>
</tr>
<tr>
<td>Problem Focused</td>
<td>Required</td>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Required</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
</tr>
</tbody>
</table>

**Coding**

- Coding must be supported by documentation
- Primary diagnosis is the reason for the encounter
- CC does not have to match primary diagnosis
- Do not code pre-existing conditions or diseases that do not affect the current encounter
- Code ONLY conditions or diseases that:
  - Coexist at the time of the encounter
  - Affect patient care
  - Are considered in decision making
  - Are assessed and treated

**Time Spent in Patient Care Activities**

- **Face-to-face time**
  - Provider meets directly with the patient or family
  - Applies to office and other outpatient visits
- **Non-face-to-face time**
  - Provider is performing work related to the patient before or after the face-to-face time
  - Includes tasks such as retrieving records and test results, arranging for further services and communicating with other health care providers and the patient outside of the face-to-face encounter

**Late Entries in AHLTA**

- Documentation and/or provider's signatures after the date of service
- Late entries, addendums, or corrections must show the date of entry and the date patient was seen for services
- Acceptable statements to reference original date of service shall contain wording such as:
  - "Late Entry: patient was seen on MM/DD/YYYY"
  - "Late Entry: I saw the patient MM/DD/YYYY"
  - "Late Entry: original date of service MM/DD/YYYY, note written on MM/DD/YYYY"
**Diagnosis Coding**

- All diagnosis codes are to be coded to the highest level of specificity
- The reason for the encounter is the first listed diagnosis code
- If a patient is experiencing an adverse effect from a medication, also code the complication

**Example**

A patient with a DVT being seen for warfarin management that is experiencing hematuria:

- Code the reason for the visit: V58.83 [Z51.81] Encounter for therapeutic drug monitoring
- Code the drug that needs monitoring: V58.61 [Z79.01] Long term (current) use of anticoagulants
- Code the medical condition for which they are taking the drug: 453.40 [I81.40x] DVT
  
  *a sixth digit is required*
- Code the complication: 599.70 [R31.9] Hematuria

**Activity – Diagnosis Coding**

Example

A pregnant patient on heparin for DVT and comes to the clinic for anticoagulation management

How would you prioritize the diagnosis coding?

Correct Order:

- Code the reason for the visit: V58.83 [Z51.81] Encounter for therapeutic drug level monitoring
- Code the drug that needs monitoring: V58.61 [Z79.01] Long term (current) use of anticoagulants
- Code the medical condition for which they are taking the drug: 453.40 [I81.40x – a 6th digit is required] DVT

**Medication Therapy Management**

- Required Elements of Documentation:
  - Review of the pertinent patient history
  - Medication profile
  - Recommendations for improving health outcomes
  - Treatment compliance
### Medication Therapy Management

- The primary diagnosis should be V58.83 \([Z51.81]\): visit for therapeutic drug monitoring
- Time-based CPT codes should be placed under the primary diagnosis code
  - 99605 - New patient, first 15 minutes
  - 99606 - Established patient, first 15 minutes
  - 99607 - Each additional 15 minutes for new or established patient. Adjust units of service to reflect total time spent
  - You must annotate total time spent

### Anticoagulation

- Within the Chief Complaint (CC), document the cycle number/INR readings in the cycle as follows:
  - Cycle ____ Cycle Start Date _____ INR #
    - Example: Cycle 1; Cycle Start Date: 4 March 2015; INR #1
  - Start date is the first day the patient took the med
- INRs not performed by the clinical pharmacist may be counted as part of the total INRs.
  - Supporting documents should be scanned into HAIMS as applicable.

### E&M encounter coding

- Anticoagulation management services are globally billed services and workload count E&M codes are used only at the end of each 90-day cycle when the minimum number of INRs are documented

### Medication Therapy Management

- Medication or Labs ordered must be under the appropriate diagnosis code
- The E&M code is 99499

### Anticoagulation

- Medication or labs ordered must be under the appropriate diagnosis code
- If point-of-care (POC) testing for PT/INR is performed, add the following procedure codes:
  - 36416 – Collection of Capillary Blood Specimen
  - 85610 – Prothrombin Time (PT)
- Document patient’s understanding medications prescribed, labs ordered and preparation required, and when to return to the clinic if symptoms are not resolved

### Anticoagulation

- 99211: If the length of the referral is limited and is determined to be 89 days or less, all visits should be coded with E&M code 99211
  - This can be done retrospectively in CHCS if a patient separates from your service before 90 days of treatment are completed.
Anticoagulation

- **99363**: Anticoagulation management, initial 90 days
  - Initial cycle is at least 90 days and 8 INR readings (may be longer to include required INR readings)
  - Initial cycle starts at first referral or the first visit after ANY break in care or hospitalization
  - After a break in care or hospitalization, must have at least 90 days and 8 INR readings
  - Face-to-face encounters only

- **99364**: Anticoagulation management, subsequent 90 days
  - Subsequent cycles consist of at least 90 days and 3 INR readings
  - Face-to-face encounters only

- **99499**: Unlisted Evaluation and Management Service
  - All encounters that are not the culmination of a 90-day cycle with the minimum INR readings to include T-Cons

Activity - Anticoagulation

- Ms. Jones is returning to your clinic for warfarin management after 28 days in a rehab facility following an ischemic stroke. She was restarted on her warfarin on 9/4/2015. Her INRs reported to you from the rehab facility have been as follows:
  - 1.5 on 9/4/2015
  - 2.5 on 9/11/2015
  - 2.3 on 9/18/2015
  - 2.6 on 10/2/2015
  - 2.5 on 10/16/2015

- What is the cycle number, start date, and INR # for this visit?
  - Cycle 1 Cycle Start Date 9/4/2015 INR # 6

- When can you code a workload count E&M code for Ms. Jones?
  - On or after 12/3/2015

- What will be the E&M code that you use to code the workload count visit?
  - 99363

- How many INR readings must you have to code the selected E&M code?
  - 8 INRs

Injections Administered During an Encounter

- **96372**: Therapeutic, prophylactic, or diagnostic injection; *subcutaneous* or *intramuscular* should be added to the appropriate diagnosis code.
  - Documentation should include name of the medication, dose, lot number and expiration date, and location of the injection.

Tobacco Cessation Counseling

- May be primary purpose of visit or additional problem addressed during the encounter
- The diagnosis codes that should indicate tobacco use (current or history)
**Tobacco Cessation Counseling**

**Documentation requirements**
- Tobacco usage (yes, no, previous history)
- Type and amount of tobacco product used daily
- Risks of continued tobacco usage
- Benefits of quitting
- Resources available for quitting (classes, medication, etc.)
- Total time (in minutes) spent counseling

**For individuals who do not have signs or symptoms of tobacco-related disease**
- G0436: Tobacco-use counsel 3-10 min
- G0437: Tobacco-use counsel >10 min
- Located in the A/P section under the procedure tab - HCPCS & Durable Med Equip

**Tobacco Cessation Counseling**

- Total time spent counseling must be documented
  - For **symptomatic individuals** (associated disease)
    - 99406- Smoking and tobacco use cessation; 3-10 minutes
    - 99407-Smoking and tobacco use cessation; > 10 minutes
  - Located under E&M category “Behavior Change Intervention, Individual”

**HEDIS Coding and Compliance**

- For labs obtained from an outside source, documentation in the TSWF-MHSPHP form will allow for HEDIS credit
- Select the TSWF-MHSPHP from the Enterprise list
- Select the box corresponding with the laboratory test
  - Enter the date the test results were reported (not drawn)
  - Enter the value
- Scan supporting documentation into HAIMS

**Group Counseling and Education Sessions (Set Curriculum)**

- AHLTA encounter documentation
  - Total number of patients in class
  - Total meeting time
  - Topics discussed
  - Any written information given to the patient
  - Reference to the curriculum used

- The diagnosis code is the medical reason why the patient needs the education (e.g. diabetes, hypertension, hyperlipidemia, etc.).

**Group Counseling and Education Sessions (Set Curriculum)**

- Coding is time based and dependent on number of patients
  - 98960 – Education and training for self-management using a standardized curriculum, individual patient
  - 98961 – Education and training for self-management using a standardized curriculum, 2-4 patients
  - 98962 – Education and training for self-management using a standardized curriculum, 5-8 patients
**T-con (Telephone or Secured Messaging) Encounters**

- T-Cons must be initiated by an established patient or the guardian of an established patient
- AHLTA encounter S/O documentation must include the reason for a call

**E&M Codes are time-based**
- 99441 - Telephone E/M service; 5-10 minutes
- 99442 - Telephone E/M service; 11-20 minutes
- 99443 - Telephone E/M service; 21-30 minutes
- 99499 - Unlisted E/M service
  - Decision to see patient within 24 hours/next available visit
  - In reference to a visit in the past 7 days
  - Message was left on a messaging device
  - Communication included only non-clinical information
  - Test results provided without any medical decision making
  - Call is in reference to anticoagulation management
  - Calls initiated by the provider

**Prolonged Services without Direct Patient Contact**

- Minimum time required to report a prolonged service is 31 minutes
  - 99358: Prolonged evaluation and management service before and/or after direct patient care; first hour
  - 99359: Each additional 30 minutes
  - Adjust units of service to reflect total time spent

**Team Conferences**

- Interdisciplinary Team Conference
  - 99366 - Team Conference, Face-to-Face Contact; Face-to-face with patient and/or family, 30 minutes or more
  - 99368 - Team Conference, Without Face-to-Face Contact; Patient and/or family not present, 30 minutes or more
Relative Value Units (RVUs)

- Based on a resource-based relative value scale (RBRVS)
- Determined by the resource costs needed to provide services
- Divided into three components:
  - Work, practice expense and liability insurance
- Calculated by multiplying the combined costs of a service by a conversion factor


Relative Value Units (RVUs)

- Evaluation and Management (E&M) Coding
  - These codes describe the services not associated with a procedure or therapy furnished during a healthcare encounter
  - They classify services provided by a healthcare provider and indicate the level of service
  - E&M codes are a subset of Procedure codes (Level I HCPCS), yet are referred to as an E&M instead of as a Procedure code to distinguish between E&M services and procedural coding

Relative Value Units (RVUs)

- Procedural Coding
  - Healthcare Common Procedure Coding System (HCPCS) codes are grouped in two levels – level I being Current Procedural Terminology (CPT®) and level II being HCPCS itself
  - HCPCS codes are maintained by the Centers for Medicare and Medicaid Services (CMS) and are typically updated on a quarterly basis

Relative Value Units (RVUs)

- Level I (CPT®) Codes
  - Level I HCPCS form the major portion of the HCPCS coding system, covering most services and procedures
  - Procedure codes supersede Level II codes when the verbiage is identical
  - CPT® is published by the American Medical Association and updated annually

Relative Value Units (RVUs)

- Level II HCPCS Codes
  - Supersede level I codes for similar encounters when the level II code is more specific
  - HCPCS codes generally include supplies, materials, drugs, and certain provider services and/or procedures
  - Having a code number listed in a specific section of HCPCS does not usually restrict its use to a specific profession or specialty

Relative Value Units (RVUs)

- Quality Measures (CPT® Category II Codes)
  - Not required to be reported within the MHS
  - Supplemental tracking codes that are intended to be used for performance measurement
  - Intended to facilitate collection of information about the quality of care delivered
  - Alphanumeric and consist of four digits followed by the alpha character ‘F’
### Relative Value Units (RVUs)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>36416</td>
<td>CAPILLARY BLOOD DRAW</td>
<td>0.08</td>
</tr>
<tr>
<td>85610</td>
<td>PROTHROMBIN TIME</td>
<td>0.15</td>
</tr>
<tr>
<td>96372</td>
<td>THER, PROPH/DX INJ; SUBCU/INTMUS</td>
<td>0.70</td>
</tr>
<tr>
<td>99605</td>
<td>MED TX MGT, PHARM; 15MIN, NEW PAT</td>
<td>1.97</td>
</tr>
<tr>
<td>99606</td>
<td>MED TX MGT, PHARM; EA ADD 15 MIN</td>
<td>1.97</td>
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</table>

### Role of Pharmacy Technicians in Coding Patient Encounters

- Pharmacy Technicians are provider extenders
- Documentation of vital signs, screening questionnaires, patient history, etc.
- Documentation of administrative encounters
  - e.g. chart reviews, pill counts, T-Cons
  - Encounters signed by pharmacist / E&M 99499
- Mid-cycle warfarin results

### Activity – RVUs

- 50 minute MTM encounter for diabetes management of established patient
  - 99606 x 1 = 1.97
  - 99607 x 2 = 3.94
- 5 minutes spent counseling patient on smoking cessation
  - G0436 = 0.39
- Insulin administered to patient during encounter
  - 96372 = 0.7
- Total RVUs = 7.01

### Key Points

- Extent of documentation in the note is dependent on the focus/complexity of the encounter
- CPT Codes are used to document procedures, E&M Codes are used to document services provided
- RVU generation is based on appropriate documentation of CPT and E&M coding
  - Must document time spent for time based codes and number of patients for group encounters
  - Failure to document minimum standards will result in encounter being downgraded to 99499
- Leverage your technicians!
Answer to Self-Assessment
Question 1

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Answer to Self-Assessment
Question 4

Pharmacy technicians can help the clinical pharmacist document patient encounters in AHLTA and positively impact encounter coding
A. True
B. False

Additional Resources

• Clinical Pharmacist Coding Guide for Ambulatory Care Services, Version 1, Patient Administration Systems and Biostatistics Activity, September 2015

• MHS Professional Services and Medical Coding Guidelines Fiscal Year 2015

Closing Remarks

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