Care Coordination Toolkit

Proper Use of Coordination of Care Codes with
Children with Special Health Care Needs (CSHCN)

March, 2004

Developed by the Center for Infants and Children with Special Needs.
Cincinnati Children's Hospital Medical Center.
&
The National Center of Medical Home Initiatives for Children with
Special Needs

Proper use of Coordination of Care Codes with CSHCN

Billing for the *Coordination of Care* codes requires an understanding of the individual codes, proper documentation, and an easy to follow billing slip.

Coordination of care (physician management) codes:

These codes are for *physician time only* and, ideally, should not be used until verifying that the patient's insurer will cover them and the diagnoses that the care was provided for. For example, Ohio only reimburses for these codes through their Title V Program (BCMH) and will <u>not</u> cover these services if they are provided for a developmental or mental health diagnosis.

Prolonged Services (with direct patient contact)

These are used when a physician provides prolonged service in an inpatient or outpatient setting that is beyond the usual service provided. They can be billed in addition to the E/M code.

Inpatient

99354	first 74 min
99355	each additional 30 min

Outpatient

99356	first 74 min
99357	each additional 30 min

Prolonged Services (without direct patient contact)

This refers to such services as reviewing records, communication with other providers or the patient &/or family.

99358	first 74 min
99359	each additional 30 min

Case Management Services

This refers to *Team Conferences* needed to coordinate the activities of patient care. They may occur during a hospitalization or after discharge and the patient or family need not be present. **Each physician present can bill this code separately.

99361	approximately 30 min
99362	approximately 60 min

There are additional codes for *phone calls* which involve active management of a problem over the phone, i.e. the after hours call that prevents an ER visit. They can also be used when management or coordination involves phone communication with a pharmacy, lab, social worker, home care provider, therapist, or other physician.

99371	brief call (<u><</u>10 min)
99372	intermediate call (10-20 min)
99373	complex call (<u>></u> 20 min)

To bill for *special reports* such as such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. This code is not an add on code (i.e., it does not have to be reported in conjunction with a face-to-face E/M visit) and it does not require face-to-face contact with the patient/parent. Medicare does not assign any relative value units to this code.

99080

Modifiers

The *–25 modifier* should be used when symptoms requiring significant amounts of physician work beyond preventive care are encountered during a preventive medicine visit (checkups) of a child with special health care needs. This would be added to the end of E/M code and billed with the preventive medicine code. Thus, a 5yo with chronic lung disease, seizures, and feeding problems comes in for his yearly WCC and the physicians spends additional time evaluating and treating his chronic problems… The physician can then bill;

99393	5yo preventive care visit
99214-25	E/M code for the additional time spent on the child's special needs.

Care Plan Oversight

These codes refer to the *work spent over a 30 day period* to supervise the care plan for patients, i.e. development and review of care plans; review patient status reports, test results, and correspondence from other health care professionals. These codes do not signify the work done to initially set up the care plan.

99374	Home care 30-60 min
99375	Home care >60 min
99377	Hospice care 30-60 min
99378	Hospice care >60 min
99379	Nursing home 30-60 min
99380	Nursing home >60 min

Proper Documentation:

The *managing physician* must document all phone calls, care conferences, review of old records, subspecialty letters, test results, etc. as well as the time spent on each. Office staff who interact with the patient, family, other offices, &/or the physician must also document what they do but must also indicate the *time spent discussing and getting direction for the encounter with the managing physician*. Thus a nurse may spend 1 hour on the phone with the family dealing with a new problem and calling in new meds but the office can only bill for the time the nurse spent discussing and being directed by the managing physician which might only be 10 minutes.

Billing Form

This form should be easily accessible and can be placed in the front of the patient's chart and all staff involved in the patients care should fill it out but remember it is only for physician time. Note: depending on the diagnosis/ICD-9 you enter can determine your eligibility to get reimbursed.

Date	Initials	Plan of Care 30-60	>60	Phone Calls <10	10-20	Care Conference >20	30	60	Review Records labs	tests	Comments

Office Tips:

- Identify eligible patients, if billing to state programs (Appendix I)
- Label charts (Appendix I)
- Keep billing form in front of chart
- Train all staff to document care coordination activities
- Meet with your billing department to discuss strategies on how to bill for these codes. (For example, Title V may not be the payer of last resort in this situation and may be the first designated payer for these codes. Some systems are set up to bill private insurance and then Medicaid and then Title V and you may need to work on a new system to bill this properly.)
- Design a system for your practice on how to tally and submit billing information

Appendices:

I.   **Identification of CYSHCN: Tools and Strategies**
         How to Label / Flag the Chart: Tools and Strategies

II.   **Forms**

III.   **How to Negotiate with Public and Private Insurers: Tools and Strategies**

IV.   **Selected Vignettes**

Appendix I
Identification of CYSHCN: Tools and Strategies:
How to Label / Flag the Chart: Tools and Strategies

1. The Center for Medical Home Improvement Domain of Chronic Condition Management (CCM). This information is part of the medical home index tool kit and encompasses several issues relating to the extra layers of care and care continuity necessary for each child with special health care needs. Each of the six themes associated with this domain relates to a specific care and care continuity concern.
   1. Identification of Children in the Practice with Special Health Care Needs
   2. Care Continuity
   3. Continuity across Settings
   4. Cooperative Management Between Primary Care Provider and Specialist
   5. Supporting the Transition to Adult Health Care Services
   6. Family Support
   © Center for Medical Home Improvement 2001.

   For the purposes of the toolkit, we have extracted the information only related to identification of children in the practice with special needs. For more information on the medical home index tool kit, go to: http://www.medicalhomeimprovment.org

2. **Responses from the Medical Home Listserv posted on March 1, 2004**

   Request: For practices involved in a quality improvement process to increase their medical homeness for children and youth with special needs and their families.

   How did you start to identify children and youth with special needs in your practice/clinic? and how did you flag or label the chart once you identified your group? Please include any tools you used or developed.

CHRONIC CONDITION MANAGEMENT:

2.1 Identification of children with special health care needs (CSHCN) in the practice

A *CSHCN* list is generated by applying a definition, the list is used to enhance care and/or define practice activities (e.g. to flag charts and computer databases for special attention or identify the population and its subgroups). Diagnostic codes for *CSHCN* are documented, problem lists are current, and complexity levels are assigned to each child; this information creates an accessible practice database (see definitions and code lists pages 168-170).

Tangible Examples:

- After the practice chooses a definition of special health care needs, children fitting that definition have their files marked with an indicator (sticker, "CSHCN" or other electronic identifier or prompt) to identify them as having special needs.

- A complexity score indicating the level of care, care coordination and follow-up a child's condition is assigned to each CSHCN (see complexity scoring examples from Phoenix Pediatrics and the HOMES complexity score from the Center for Medical Home Improvements, pages 172-174).

Scenario #1

An identifier, such as "CSHCN" or "Special Needs" is used on the patient's computer file; this may be printed out on the "day sheet" and highlighted to help staff prepare for the visit. Staff will see this "flag" and be alerted to note modifications or plan for any family requests or accommodations during that child's appointment.

Scenario #2

ABC Pediatrics identifies children and families according to an applied definition; they ask for parent permission to "sticker" the chart and then provide a description of their medical home efforts to improve the quality of
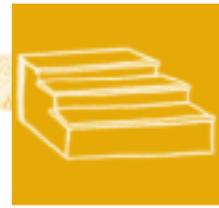
care. They then add the child to a "population list" and assign a HOMES complexity score to the child. This allows them to quantify and qualify their population, plan for care coordination needs and staffing, and demonstrate their efforts toward providing a medical home (see Exeter CSHCN definition, their medical home explanation, and the HOMES complexity scoring tool on
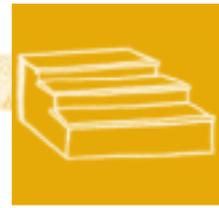
DEFINITIONS OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

US Maternal and Child Health Bureau

Children with special health care needs as defined by the US Maternal and Child Health Bureau are those who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally (USDHHS, MCHB, 1997). Statistics show that this definition includes between 16-18% of all children.

Ruth Stein, et al (1993)

A chronic health condition must: 1) have a biologic, psychologic or cognitive basis, 2) have lasted or is expected to last at least one year, and 3) produces one or more sequelae including: limitation of function, activities, or social role; dependency upon medications, special diets, medical technology, assistive devices, or personal assistance to compensate for limitations; the need for related medical, psychologic, educational or other services over and above the usual for the child's age; or require ongoing treatments, interventions or accommodations at home or in school.

Foundation for Accountability (FACCT) screener identifies population of CSHCNs

The Children With Special Health Care Needs (CSHCN) screener was developed by FACCT in response to the need for a brief, standard, parent self-administered method to validly identify a denominator of children with chronic or special health care needs for the purpose of assessing health plan and provider quality. The results of the CSHCN screener can be used to stratify performance measures for children with and without special health care needs and to estimate the prevalence of CSHCN in health plans and other settings.

- The screener contains 5 questions, each with follow up parts asking about the presence and duration of any health conditions.
- There are 7 ways to qualify as a child with chronic or special health needs on the CSHCN screener
- The screener may be parent self-administered or telephone interviewer administered.
- The screener questions uses health consequences-based, rather than diagnosis-specific criteria, to identify children.
- The CSHCN screener takes 1-2 minutes to administer.
- The CSHCN screener has been field-tested by FACCT in sixteen different samples: 16-20% children in population-based samples were identified has having chronic or special health care needs, 50-65% were identified in samples prescreened using diagnostic criteria and over 95% identified in a population of children receiving SSI benefits.
- The CSHCN screener is not intended for in-depth, clinical assessment of a child's health needs and should not be used for such.
- For more information about the screener: www.facct.org
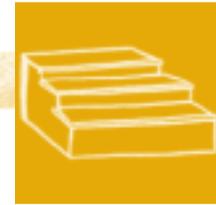
EXETER PEDIATRICS
Children with Special Health Care Needs Identification Criteri
(Please place a pink sticker on the chart of any child/adolescent identified or at risk for a special health care need).

Chronic health conditions in children may:
- Last at least one year   • impact family and school life   • impact development
- Result in limited function/ • & involve dependence upon:
       activities, services, treatments, and special programs at distant
       centers, in the community, at home and/or in school.

Examples of chronic health conditions include but are not limited to:

BIOLOGICAL	PSYCHOLOGICAL	COGNITIVE	OTHERS WHO ARE "AT RISK" OR GENERATE CONCERN
asthma diabetes seizure disorders autism/PDD Down Syndrome bee sting/food allergies recurrent UTIs recurrent otitis media cerebral palsy hearing/serious vision impairments some pre-term infants developmental delay	depression eating disorders abuse/neglect substance abuse attachment disorder temperament disorder suicidal ideation or suicide attempt	ADD ADHD learning disabilities mental retardation language disorders processing disorders	Children/adolescents living: in poverty, in a foster home, with alcohol or drug dependent parents or guardians, with a depressed or ill parent(s), or amidst domestic violence. Pregnant teens or teens who demonstrate risky behaviors.

This definition is meant to provide guidance in identifying children with special health care needs. It is not meant to represent inclusion or exclusion criteria.
If you have a question about a particular child, please check with Greg Prazar, MD or Jody Couillard, Care Coordinator.
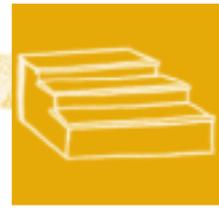
CENTER FOR MEDICAL HOME IMPROVEMENT
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)
Common ICD-9 Codes

ACNE	706.1	HEARING LOSS (SEVERE)	389
ADD	314.00	HEMPOHILIA	286.0
ADHD	314.01	HIV	042
ALLERGIC RHINITIS	477.9	HYPERTHYROIDISM	242.9
ALLERGIES	995.3	HYPOLASTIC LEFT HEART	746.7
ANXIETY DISORDER	300.00	HYPOTHYROIDISM	244.9
ASTHMA	493.90	IMMUNODEFICIENCY DISORDERS	279.3
AUTISM	299.0	JUVENILE RHEUMATOID	
BEE-STING ALLERGY	989.5	ARTHRITIS	714.30
BIPOLAR DISORDER	296.80	LEAD POISONING	984.9
BRONCHOPULMON DYSPLASIA	770.7	LEARNING DIFFICULTIES	315.2
CARCINOMA	140–239	MENTAL DISORDERS	300.9
CARDIO NEUROGENIC SYNCOPE	780.2	MUSCULAR DYSTROPHY	359
CEREBRAL PALSY	343.9	NYSTAGMUS	379.50
CHILD ABUSE	995.5	OBESITY	278.00
CHRONIC LIVER DISORDER	571.9	OBSESSIVE COMPULSIVE	
CHRONIC RENAL DISORDER	582.9	DISORDER	300.3
CHRONIC RESPIRATORY ORDER	519.9	CHROHNS DISEASE	555.9
CHRONIC SERIOUS OTITIS MEDIA	381.1	PANIC DISORDER	300.01
CHROHNS DISEASE	555.9	PKU	270.1
COLOBOMA	743.49	PREMATURITY	765.1
CONG.DACRYOSTENOSIS	743.65	SCOLIOSIS (CONGENITAL)	754.2
CONGENITAL ANOMALIES	740–759	(ACQUIRED POSTURAL)	737.30
CONSTIPATION	564.0	CYSTIC FIBROSIS	277
CYSTIC FIBROSIS	277	SEXUAL ABUSE	995.53
DEPRESSION	311	SICKLE CELL DISEASE	282.6
DEPRESSION (ACUTE)	296.2	SEIZURE NOS	780.39
DEPRESSION (RECURRENT)	296.30	SPECIFIC LEARNING DISABILITY	315.2
DEVELOPMENTAL DELAY	783.4	SPEECH/LANGUAGE DISORDER	315.31
DIABETES	250.0	STRABISMUS	378.9
DYSLEXIA	784.61	TIC	333.3
DEVELOPMENTAL	315.02	TOURETTE DISEASE	307.2
ECZEMA	692.9	TRAUMATIC BRAIN INJURY	850–854
ENCORPESIS	787.6	UTI	599.0
ENCORPRESIS (NON-ORG. ORIGIN)	307.7	VISION LOSS (SEVERE)	369.9
EPILEPSY	345.9	WERNIG-HOFFMAN	335.0
(GENERAL.NON-CONCLUSIVE)	345.0	WITNESS TO VIOLENCE	V62.8
EPILEPTIC CONVULSIONS	345.10–345.91		
EXPRESSIVE SPEECH DELAY	315.39		
FAILURE TO THRIVE	783.4		
FEBRILE SEIZURE	780.31		
FETAL ALCOHOL SYNDROME	760.71		
FOSTER CARE	V61.29		
FRACTURE	800–829		
FRAGILE X	789.83		
GASTROESOPHAGEAL REFLUX	530.1		
GROSS MOTOR DELAY	783.4		
HEAD TRAUMA	959.01		

Add:

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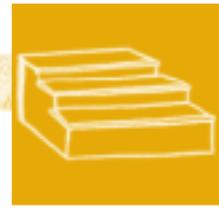
Complexity Index (Phoenix Pediatrics) David Hirsch, MD

Complexity	Description	Example
0	Well, no medical problems	Well Child
1	One moderate medical problem, involving one organ system with complications	Moderate asthma
2	One moderate or severe medical problem, involving one organ system with complications	CP, contractures
3	Two or more moderate or severe medical problems involving two or more organ systems	CP, epilepsy, MR
4	Two or more moderate or severe medical problems involving two or more organ systems with complications	Epilepsy, BPD, Tracheotomy, vent dependent
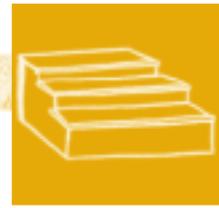
EXETER PEDIATRIC ASSOCIATES
"HOMES" COMPLEXITY INDEX

The purpose of this index is to identify the level of complexity/intensity involved in supporting children with special health care needs in our practice. See reverse side for explanation of terms.

Score each category 0, 1, or 2 (0 means no service, activity or concern)

Category	Criteria	Score
Hospitalizations, ER Usage & Specialty Visits (in last year)	1 = 1 hospitalization, ER or specialist visit for complex condition 2 = 2 or > hospitalizations, ER or specialist visits for complex condition	
Office Visits and/or Phone Calls (in last year, over and above well child visits, +/– extra charges).	1 = 1-2 office visits or MD/RN/care coordinator phone calls related to complex condition 2 = 3 or more office visits or MD phone calls for complex condition	
Medical Condition(s): One or more diagnoses	1 = 1-2 conditions, no complications related to diagnosis 2 = 1 or 2 conditions with complications <u>or</u> 3 or more conditions	
Extra Care & Services at PCP office, home, school, or community setting (see *Services*)	1 = One service from the list below 2 = Two or more services from the list below *Services*: Medications, medical technologies, therapeutic assessments/treatments/procedures, & care coordination activities.	
Social Concerns	1 = "At risk" family/school/social circumstances are present 2 = Current/urgent complex family/school/social circumstances are present	

Complexity Scores will range from 0-10 (0-3 low, 4-6 medium, 7-10 high).

Name _____ Date _____ Total Score = _____

6/18/01

"HOMES" COMPLEXITY INDEX
GLOSSARY

A complexity score for each identified child will help providers/staff prepare and budget time more effectively for each child. It will also help administrators justify essential extra time spent by the practice in the care and support of the children and their families.

<u>Medical Home</u>: Community-based primary care provided by the practice which is: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent (American Academy of Pediatrics definition).

<u>Children with Special Health Care Needs (CSHCN)/(Complex Condition):</u> Children with special health care needs are defined by the US Maternal and Child Health Bureau as those children who have, or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. The condition must be present for at least one year. These children require health and related services of a type or amount beyond that generally required by children.

<u>Specialist Visit:</u> Includes visits to MD's, audiologists, feeding specialists and similar others.

<u>MD Phone Calls:</u> Includes time on phone with family, physicians, agencies/organizations, schools & others.

<u>Complications</u>: Medical, emotional, or social concerns related to the complex condition. For example, conditions which prove particularly difficult to manage, like depression or behavioral issues secondary to the complex condition, or learning difficulties and/or falling behind in school as a result of the condition (missed school or missed parent work days).

<u>Medical Technologies</u>: Some examples include G-tubes, infusions, tracheotomies, communication devices, or the need for other medial equipment and supportive technologies.

<u>Therapeutic Treatments</u>: Some examples include physical, occupational or speech therapies, respiratory treatments such as postural drainage or regular nebulizer use, counseling or other therapeutic interventions.

<u>Care Coordination Activity Examples</u>:
- Providing assessments and monitoring of child and family needs
- Participating in parent/professional practice improvement activities
- Offering supportive services including counseling, education and listening
- Facilitating communication among PCP, family and others
- Developing, monitoring, updating and following up with care planning and care plans organizing wrap around teams with families
- Supporting meeting recommendations and follow-up
- Coordinating inter-organizationally
- Advocating with and for the family (e.g. to school, daycare, or health care settings)
- Finding, coordinating and promoting effective and efficient use of current resources
- Monitoring outcomes for child, family and practice and other activities needed and/or requested by the child and family.

<u>**"At risk" circumstances**</u>: Children/adolescents living in poverty, in a foster home, with parents or guardians who are alcohol or drug dependent, depressed or ill, or living with domestic violence. Also at risk are pregnant teenagers and teens who demonstrate health risk behaviors (e.g. smoking, drugs, alcohol, firearms, dangerous driving habits, etc.).
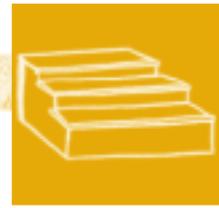
CSHCN CHART IDENTIFICATION & WHO NEEDS A MEDICAL HOME – EXPLANATION

Parent Permission to sticker/identify the chart as a CSHCN

We are trying to find a better way to give care to patients who have a condition lasting longer than a year by identifying the chart with a sticker (provide a medical home). Is that all right with you?

Explanation (this is printed on nice handout paper):

Who Needs a Medical Home?

There are over 200 different kinds of health conditions in children that may cause physical, emotional or learning challenges. Some examples of these health issues are: cancer, diabetes, depression, addictions, learning and developmental challenges, and living with adults who have physical or emotional health concerns.

We have formed a Caregiver/Parent team at Exeter Pediatrics as part of a project linked with The Hood Center for Children and Families at the Children's Hospital at Dartmouth. This partnership will promote quality care for children and families with health care issues. We would appreciate hearing your comments and suggestions to help us in this effort.

Many families want a central place where their children can receive medical care from knowledgeable and supportive professionals. They want medical "partners" who will work with them to keep their children healthy and to help them find needed supports and resources. This idea is called a "Medical Home".

At Exeter Pediatrics we are working hard to become an effective Medical Home for families we serve. We believe that supporting families not only promotes healthy children but also promotes healthy families.

If you would like to learn more about this project or have questions regarding your child's care, ask your health care provider or our Care Coordinator, Jody Couillard, at 772-8900 Ext. 175.

Responses from the Medical Home Listserv posted on March 1, 2004

The inclusion of any resource or link in these pages does not imply endorsement. As information changes rapidly, please check with each sponsoring organization as to whether the information you are receiving on their web site is current. If you have information or resources to add to this request, please e-mail us at medical home@aap.org.

Posted March 1, 2004

Request: For practices involved in a quality improvement process to increase their *medical homeness* for children and youth with special needs and their families.

How did you start to identify children and youth with special needs in your practice/clinic? and how did you flag or label the chart once you identified your group? Please include any tools you used or developed.

Responses:
Getting Started | Identification Examples and Tools | Flagging the Chart | Lessons Learned | More Tools

Getting Started
The Center for Medical Home Improvement (CMHI) has put together recommended guidelines and information in their medical home tool kit on pages 168-172. It goes through how to facilitate the process of identifying CYSHCN with a practice and how to get started. The first suggestion is to figure out what is possible. Here is a brief outline of the process:

1) Determine to identify, flag and quantify their population
2) Pick a definition
3) Identify in real time, prospectively and add CSHCN to the problem list so that they can be pulled up by computer
4) Use natural opportunities to help them (flu shot clinics for example)
5) Identify and apply a complexity score
6) Develop the mentality of whenever a child is brought to their attention asking if they are identified
7) Being prepared to respond with why are you asking this/or doing this/or labeling my child and what is a medical home anyway.

Physician Recall and Computer Report by Diagnosis and Identification while in the Process of Care
‣We originally started identifying CSHCN by recall and easily had a list of over 100 kids. We than ran computer reports for specific diagnoses to ID additional patients. Now new patients are referred by our MDs as they are identified (usually at a rate of 3-4 per week)
-Palmetto Pediatric and Adolescent Clinic. Columbia, SC

‣We printed out a list of all of our patients, by primary care physician, and asked each doctor to highlight the patients that met criteria (their own criteria). We then got in a supply of sturdier charts and have been migrating the patients' records to those charts as they come in or we have time. We continue to identify patients not picked up in the initial process as we see them - docs, nurses, even the occasional patient, has helped in this process.
-Utah Medical Home Project

‣Doctors identify the patients and place them in order of importance for the care coordinator to contact. The practice has prioritized the list as all are not able to be served with/ the care coordinators limited number of work hours.
-Red Rock Pediatrics, AZ

‣Referrals from PHN and observations within the clinic setting.
-Waianae Coast Comprehensive Health Center. Kaneohe, HI

‣We've identified over 300 kids by 1) physician recall, 2) computer recall by diagnosis, such as Down Syndrome, autism, cerebral palsy, seizure disorder, prematurity, bipolar disorder, childhood malignancy, etc. and 3) identification while in the process of care (usually when you have gotten way behind taking care of a special needs child!) Our docs are starting to be more proactive in identification, especially after being given a list of kids they've already identified.
-Chapel Hill Pediatrics and Adolescents, P.A. Chapel Hill, NC

CSHCN Screener

▶We conducted a study of the use of the CSHCN screener© (Bethell, Read, Stein et al., 2002) to identify this group of children in primary care settings. It shows potential for helping primary care providers identify this group. The reference for this paper is below.
-University of Missouri, Department of Health Psychology

The CSHCN Screener© is a five item, parent survey-based tool that responds to the need for an efficient and flexible standardized method for identifying CSHCN. The survey can be administered in person or by telephone. The screener is specifically designed to reflect the federal Maternal and Child Health Bureau definition of children with special health care needs. (4 pages).

Farmer, J.E., Marien, W.E., & Frasier, L. (2003). *Quality improvements in primary care for children with special health care needs: Use of a brief screening measure*. Children's Health Care, 32 (4), 273-285.

Title V list to start and then develop office criteria

We started by getting a list from our title V agency. It turned out to have about half of the kids we were seeing with complex health care needs, but gave us a start. But, lots of our Title V patients did not really need the care coordination services we are providing as part of our medical home project. So we came up with the following criteria for doing care coordination:

To be enrolled as a medical home project participant, a patient must have a chronic medical condition that would make them CRS (Title V) eligible AND

- 2 or more regular consultants
- Frequent ER visits
- Frequent hospitalizations
- Family support problems
- School problems
- Financial problems impacting access
- Mental health problems

-Beaufort Pediatrics, South Carolina

County and State Collaboration with Practices to Identify CSHCN

The Alameda County Medical Home Project in California has assisted their local primary care providers to identify CSHCN in their practices in several ways:

1. Provide practices with a list of their patients enrolled in CA's Title V program for CSHCN (called CCS). These data unfortunately often are out of date, but it's a start (few PCPs already have these children noted in any accessible way), and they take corrections from the PCPs and forward them to CCS program staff so they can correct their database.
2. Facilitate Primary Care Physicians (PCP) getting a list of their patients who are active CCS clients from the county Medicaid managed care plan; this list will include only those children who are members of that plan (the alternate plan is private and statewide and does not share its data by county), but it's another way to expand PCP knowledge. Also, as in above, we forward to the local CCS program any changes noted in PCP for CCS kids based on the plan's list so CCS can correct its database.
3. Our project's parent body, the Alameda County Committee on Children with Special Needs, developed a Special Needs Risk Factor Scale (Guidelines) a number of years ago specifically to identify those children who need more assistance in the primary care setting. The Scale was explicitly designed to include psychosocial risks since our experiences indicated that for many providers, the psychosocial issues were more difficult to handle in the primary care setting than the medical conditions. Five years ago we negotiated an agreement with our county Medicaid managed care plan to pay a risk-adjusted primary care capitation rate to pediatricians (and now family physicians) serving children who reach a threshold score of 4 points on the Scale. Our Medical Home Project encourages medical home practices to attend the Risk Factor Scale training and to participate in the risk-adjusted capitation program. It's a win-win: PCPs identify both medical and psycho-social risks in their patients, which enhances their ability to serve as medical homes to these kids and their families, and PCPs serving children with moderate or high needs (as determined by the Scale) get more

money from the plan. We have responded to PCP feedback (through surveys we've conducted over the years) and made some changes in the Scale, and we collaborate with the plan to analyze the data from the Scales to determine what other steps we should take to assist PCPs and families.

Flagging the Chart

▶We changed the plain manila charts to bright blue charts for each of the identified patients. We also changed the patient's status in are computer to read "CSHCN" and added an audible notification whenever the account is accessed. EVERYONE in our offices knows that a blue chart means CSHCN.
We then developed a "Care Plan" which is posted in the front of the chart as well as shared with each of the child's providers from schools to other MDs and therapists. The family is also given a copy of the care plan along with a letter to keep handy if they should ever need to call EMS, be seen out of town, etc.
-Palmetto Pediatric and Adolescent Clinic. Columbia, SC

▶We put a * behind the name in the computer. This will then come up whenever they call for an appointment or with questions. There also is a list of diagnosis, medications, specialists, etc that this triggers at each encounter.
-Reading Pediatrics – Wyomissing, PA

▶By placing a MEDICAL ALERT label on the outside of patient's chart and by placing a comment in our computer system which, when the patient was pulled up, would tell the operator to allow more time for appointments.
-Pediatricians of West Houston

▶We use a computerized scheduling system, and all my special needs patients have notes attached to their names as "extra-time" patients. The schedulers know to book them differently, roughly twice the time of an otherwise healthy child. There are occasional glitches, but in general it works for me.
-The Everett Clinic - Mukilteo, WA

▶We have an electronic medical system called Encounter Pro from JMJ technologies which allows alerts to be placed on the patient's chart so the alert is the first thing you see when you enter the chart. We put our special needs children's diagnoses there. It is also easy to see the diagnoses from previous visits when scrolling through the chart.
-Growing Up Pediatrics - Cornelius, NC

▶Once the child is identified, their chart is marked with a non-stigmatizing green sticker, and marked as "Special" in Medical manager to alert the schedulers to give more time for that appointment.
-Chapel Hill Pediatrics and Adolescents, P.A. Chapel Hill, NC

▶We marked the charts with a piece of colored tape, and have been adding other children as they come into the office. Since the charts are marked, it's easy to tell when the patients come in if we have already added them to our registry.
-Beaufort Pediatrics, South Carolina

▶Once I've contacted the patient and they choose to be part of the Medical Home program, their file is change to another color. Because of the color of the chart, the staff knows when any information comes in about this patient, the chart goes to me. When I meet with the patients, the notes are in the chart so everyone can review them.
-Red Rock Pediatrics, AZ

▶Our front office staff have a list of Highly special need patients that are provided with longer appointment times and not made waiting for prolonged periods in the waiting area.
-Waianae Coast Comprehensive Health Center. Kaneohe, HI

A three step approach to identifying CYSHCN and providing comprehensive, coordinated care:

1. We have a front summary sheet where we list all " encounters" and a "problem list". The front summary sheet also has all the "well child" periodicity components with a blank indicated for result or action. On a monthly basis when we have our clinic meeting, 5-10 charts are pulled for each pediatrician and the physicians, assistants, nurses and we do a 10

minute audit of a particular item. Examples; review last encounter and determine if is was recorded; look for referrals and see if result is present etc and acknowledged. Continuing quality improvement, quality assurance-it has a lot of names but as pediatricians we know behavior changes in small steps.

2. Most helpful , however, is that the staff pulls all charts the day before a visit and we review them the day before as mini teams-nurse, assistant, front office-we have work sheets on the each chart with notes as what is to be done. Sure , many patients are scheduled the same day but the staff "looks" for the sheet and reviews. It creates an office "culture" of all caring for the patient. We also call mom, dad, and family and include them in the team process by asking that they bring in info-school report, audiology report etc if we do not have it in the chart. It improves our care and also improves our efficiency. We are not continually looking for charts; attempting to secure a referral result while the child and family are in the clinic. Our care is also more comprehensive - less likely to miss a routine immunization on a patient with many other needs.

3. Once a month we invite an agency in our area to have lunch with our staff. Community health services, early intervention, homes for runaway teens, children's protective services, school personnel, home infusion etc. We realize that there are many others in the community that participate in the health of children and we like to get to know one another.

-Portland, OR

Lessons Learned

There are lists on chronic diseases, lists on conditions considered special healthcare needs, however, I find it the most practical to have each practice define who or what conditions they want to track and benefit from the medical home model understanding that then ideal is "for every child to have a medical home" and not only those with special needs. The way you define this group defines the volume of the program which is an important consideration. For instance we do not include in the list all children with chronic OM. We include some of them if they have an associated problem such as delayed speech or hearing loss. In other words start small and try it out; then include other conditions once the program is running with some degree of efficiency.
-New Mexico Medical Home Project

The National Center has compiled a list of formal assessment tools to identify children and youth with special needs that are available at: http://www.medicalhomeinfo.org/tools/identify.html

Appendix II: Forms

1. Medical Home Care Coordination Tool Physician Care Management Billing Office Form: A form to record care coordination activities by all staff. Developed by the Center for Infants and Children with Special Needs at Cincinnati Children's Hospital Medical Center.

2. Medical Home Care Coordination Measurement Tool: A form to record care coordination activities by all staff. Recommendations and guidelines on scoring the measurement tool included. Developed for the National Study of Care Coordination Costs in Medical Homes by Nashaway Pediatrics, University of Massachusetts Memorial Community Medical Group and the Department of Pediatrics, University of Massachusetts Medical School.

3. Billing Office Form. This form will allow you to consolidate all of the care coordination activities by patient, diagnosis, and activity.

It is recommended that the care coordination tools be placed in the front of the patient chart for easy access which will improve on time documentation. These forms will most likely need to be adapted to fit your practice and billing needs.

PHYSICIAN CARE MANAGEMENT

Name:_____ MR#: _____ Insurance: _____ BCMH: _____

Date	Initials	Plan of Care		Phone Calls			Care	Conf	Review records, labs, tests		Comments
		Time	Item	<10	10-20	>20	30	60	Time	Item	

Medical Home Care Coordination Measurement Tool[©]

Patient Name	Date	Patient Study Code And Age	Patient Level	Focus	Care Coordination Needs	Activity Code(s)	Outcome(s) Prevented	Occurred	Time Spent* 1 2 3 4 5 6 7	Staff	Clinical Comp.	Initials

Patient Level

Level   Description

I   Non-CSHCN, **Without** Complicating Family or Social Issues

II   Non-CSHCN, **With** Complicating Family or Social Issues

III   CSHCN, **Without** Complicating Family or Social Issues

IV   CSHCN, **With** Complicating Family or Social Issues

Focus of Encounter (choose ONLY ONE)

1. Mental Health
2. Developmental / Behavioral
3. Educational / School
4. Legal / Judicial
5. Growth / Nutrition
6. Referral Management
7. Clinical / Medical Management
8. Social Services (ie. housing, food, clothing, ins., trans.)

Rev-03/20/03

Care Coordination Needs
(choose **all that apply**)

1. Make Appointments
2. Follow-Up Referrals
3. Order Prescriptions, Supplies, Services, etc.
4. Reconcile Discrepancies
5. Coordination Services (schools, agencies, payers etc.)

Time Spent

1 – less than **5** minutes
2 –   **5 to 9** minutes
3 –   **10 to 19** minutes
4 –   **20 to 29** minutes
5 –   **30 to 39** minutes
6 –   **40 to 49** minutes
7 –   **50** minutes and greater*
        (*Please NOTE **actual minutes** if greater than 50)

Staff
RN, LPN, MD, NP, PA, MA, SW, Cler

Clinical Competence

C= Clinical Competence required
NC= Clinical Competence not Required

Activity to Fulfill Needs
(choose **all that apply**)

1. **Telephone discussion with:**
   a. Patient   e. Hospital/Clinic
   b. Parent/family f. Payer
   c. School   g. Voc. / training
   d. Agency   h. Pharmacy
2. **Electronic (E-Mail) Contact with:**
   a. Patient   e. Hospital/Clinic
   b. Parent   f. Payer
   c. School   g. Voc. / training
   d. Agency   h. Pharmacy
3. **Contact with Consultant**
   a. Telephone c. Letter
   b. Meeting   d. E-Mail
4. **Form Processing**: (eg. school, camp, or complex record release)
5. **Confer with Primary Care Physician**
6. **Written Report to Agency**: (eg. SSI)
7. **Written Communication**
   a.   E-Mail
   b.   Letter
8. **Chart Review**
9. **Patient-focused Research**
10. **Contact with Home Care Personnel**
    a. Telephone c. Letter
    b. Meeting   d. E-Mail
11. **Develop / Modify Written Care Plan**
12. **Meeting/Case Conference**

Outcome(s)

1. As a result of this care coordination activity, the following was **PREVENTED** (choose **ONLY ONE**, if applicable):
   1a. ER visit
   1b. Subspecialist visit
   1c. Hospitalization
   1d. Visit to Pediatric Office/Clinic
   1e. Lab / X-ray
   1f. Specialized Therapies (PT, OT, etc)

2. As a result of this care coordination activity, the following **OCCURRED** (choose **all that apply**):
   2a. Advised family/patient on home management
   2b. Referral to ER
   2c. Referral to subspecialist
   2d. Referral for hospitalization
   2e. Referral for pediatric sick office visit
   2f. Referral to lab / X-ray
   2g. Referral to community agency
   2h. Referral to Specialized Therapies
   2i. Ordered prescription, equipment, diapers, taxi, etc.
   2j. Reconciled discrepancies (including missing data, miscommunications, compliance issues)
   2k. Reviewed labs, specialist reports, IEP's, etc.
   2l. Advocacy for family/patient
   2m. Met family's immediate needs, questions, concerns
   2n. Unmet needs (**PLEASE SPECIFY**)
   2o. Not Applicable / Don't Know
   2p. Outcome Pending

R. Antonelli, MD, FAAP

Scoring the Medical Home Care Coordination Measurement Tool
Guidelines and Recommendations
(Developed for the National Study of Care Coordination Costs in Medical Homes)
(Supported by MCHB grant HRSA-02-MCHB-25A-AB)

Patient Name	This part of the form is for your internal use only. You should write the patient's name in this box.

Date	Record the date of the care coordination encounter. Be certain to document activities each day. **Recommendation: If you don't have an outcome by the end of the day, but you've spent 40 minutes trying to coordinate home care for a patient (for example), document the 40 minute care coordination activity for that day and code the Outcome as "2p" or "Outcome Pending". If you pick up the task the next day, and complete it in 10 minutes, you would enter a 10 minute care coordination encounter for the new day, and code the outcome "2g" or "Referral to a Community Agency".**

Patient Level	Patient Level	If the clinical staff person who codes the complexity has any question as to the correct Patient Level, the patient's Primary Physician should be consulted.
	Level Description	
	I Non-CSHCN, **Without** Complicating Family or Social Issues	
	II Non-CSHCN, **With** Complicating Family or Social Issues	
	III CSHCN, **Without** Complicating Family or Social Issues	
	IV CSHCN, **With** Complicating Family or Social Issues	

Checklist for Determination of CSHCN

1. Does this child HAVE a physical, developmental, behavioral, or emotional condition that has lasted or is expected to last at least 12 months?   Yes ___ No ___
   (If "No" or Don't Know, continue to #2)

2. Is this child AT RISK FOR HAVING a physical, developmental, behavioral, or emotional condition that is expected to last at least 12 months?   Yes ___ No ___
   (If "No" or Don't Know, continue to #3)

3. Does this child require health and related services of a **type** OR **amount** beyond that required by children generally?   Yes ___ No ___
   Includes: Medicines prescribed by a doctor (other than vitamins)
                Medical Care
                Mental Health Services
                Educational Services
                Specialized Therapies (PT, OT, Speech)
                Treatment or Counseling for emotional, developmental or
                  behavioral problems
   (If "No" or Don't Know, continue to #4)

4. Is the child limited or prevented in any way in his or her ability to do the things most children of the same age can do, due to a **chronic** medical, behavioral or other health condition?

Yes ___ No ___

(Checking "Yes" to any of the four questions places the child in either Level III or IV, depending on the presence of complicating family or social issues)

Some examples of "Complicating Family or Social Issues":
- Single Parent Home
- Divorce
- Language Barrier
- Drug / Alcohol Abuse in home
- Homelessness
- Loss of Job
- Undocumented Immigration Status
- Mental Illness in home

Focus	Focus of Encounter	Decide how to document this section
	1. Mental Health 2. Developmental / Behavioral 3. Educational 4. Legal / Judicial 5. Growth / Nutrition 6. Referral Management 7. Clinical / Medical Management 8. Social Services (ie. housing, food, clothing, ins., transportation)	**Do you want staff to document ONE area of focus per CC encounter or all that apply? It is recommended to list all, with the primary focus first.** **If there are several areas of focus, you may decide to document them on separate lines as distinct CC encounters.**

This tool will assist you to breakdown a care coordination encounter into four components.
- The **FOCUS OF THE ENCOUNTER**, list the primary focus area first.
- The **CARE COORDINATION NEEDS**, which documents all the areas of need to satisfy the care coordination encounter. You should document ALL THAT APPLY.
- The **ACTIVITY TO FULFILL the NEEDS**, which records precisely what you did and for which you document the amount of time it took you to complete the activities. You should document ALL THAT APPLY.
- The last component is the **OUTCOME(S)**. Outcome is divided into two parts – what was PREVENTED (choose ONLY ONE) and what OCCURRED (choose ALL THAT APPLY).

Care Coordination Needs	Care Coordination Needs (choose **all that apply**)	Recommendation: Write in all Needs
	1. Make Appointments 2. Follow-Up Referrals 3. Order Prescriptions, Supplies, Services, etc. 4. Reconcile Discrepancies 5. Coordination Services (schools, agencies, payers etc.)	<u>**Recommendation:**</u> **Write in all Needs that apply for that CC encounter.** **Reconciling discrepancies refers to such needs as hunting down missing data, miscommunications between family/specialists/agencies/etc, and compliance issues.**

NOTE:

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- There are FOUR boxes on the entire CCMT that can contain multiple entries (if the CC encounter included more than one)
  - o Focus of Encounter
  - o Needs
  - o Activity to Fulfill Needs
  - o Outcome – Occurred

All other boxes can contain ONLY A SINGLE ENTRY.

<u>Recommendation:</u>
Decide on entry standards – what areas must be completed and what sections are "if applicable."

Activity Code(s)	<u>Activity to Fulfill Needs</u> (choose **all that apply**)	How does a staff person decide whether an activity they are performing is recordable for the study? <u>Recommendation:</u> **If in doubt, RECORD IT!**
	1. Telephone discussion with: a. Patient e. Hospital/Clinic b. Parent/family f. Payer c. School g. Voc. / training d. Agency h. Pharmacy **2. Electronic (E-Mail) Contact with:** a. Patient e. Hospital/Clinic b. Parent f. Payer c. School g. Voc. / training d. Agency h. Pharmacy **3. Contact with Consultant** a. Telephone c. Letter b. Meeting d. E-Mail **4. Form Processing**: (eg. school, camp, or complex record release) **5. Confer with Primary Care Physician** **6. Written Report to Agency**: (eg. SSI) **7. Written Communication** a. E-Mail b. Letter **8. Chart Review** **9. Patient-focused Research** **10. Contact with Home Care Personnel** a. Telephone c. Letter b. Meeting d. E-Mail **11. Develop / Modify Written Care Plan** **12. Meeting/Case Conference**	

If it is necessary to perform several activities in the process of performing the care coordination encounter, you should list all the activities on this line and enter the combined total number of minutes required to complete these activities.

For example, you are trying to assist a family in refining an educational plan (IEP) for their learning disabled child at school.
As mentioned on the previous page,
- The **Focus** of the Encounter is (3) Educational.
- The Care Coordination **Needs** are primarily (5) Coordination of Services.

The **Activities** you perform may include:
- (1b) Telephone discussion with Parent/family,
- (1c) Telephone discussion with School,
- (12) Setting up a Meeting,
- (3c) Sending out a Letter to the Specialist/Consultant and
- (7b) Sending a confirmatory letter to the School.

All of these Care Coordination Activities are required to fulfill the Needs of the encounter, and their combined time should be recorded.

There is likely not an **Outcome – Prevented**, however if the family had needed to book a visit with the Specialist in order to sort out the problems, you would code (1b) as outcome prevented.

The **Outcomes – Occurred** might include:
- (2j) Reconciled discrepancies between the School, the family and the Specialist
- (2k) Reviewed reports and proposed IEP's
- (2m) Met family's needs, questions and concerns

Outcomes(s)		Outcome(s)
Prevented	**Occurred**	
		1. As a result of this care coordination activity, the following was **PREVENTED** (choose **ONLY ONE**, if applicable):
		1a. ER visit
		1b. Subspecialist visit
		1c. Hospitalization
		1d. Visit to Pediatric Office/Clinic
		1e. Lab / X-ray
		1f. Specialized Therapies (PT, OT, etc)
		2. As a result of this care coordination activity, the following **OCCURRED** (choose **all that apply**):
		2a. Advised family/patient on home management
		2b. Referral to ER
		2c. Referral to subspecialist
		2d. Referral for hospitalization
		2e. Referral for pediatric sick office visit
		2f. Referral to lab / X-ray
		2g. Referral to community agency
		2h. Referral to Specialized Therapies
		2i. Ordered prescription, equipment, diapers, taxi, etc.
		2j. Reconciled discrepancies (including missing data, miscommunications, compliance issues)
		2k. Reviewed labs, specialist reports, IEP's, etc.
		2l. Advocacy for family/patient
		2m. Met family's immediate needs, questions, concerns
		2n. Unmet needs (**PLEASE SPECIFY**)
		2o. Not Applicable / Don't Know
		2p. Outcome Pending

It is often the case that nothing is "Prevented" as an outcome of the care coordination activity. In this case, enter "0". However, if your efforts in care coordination prevented a child from needing to go to the emergency room, for example, please enter "1a" under Outcome – Prevented. If your careful care coordination resulted in a child avoiding a duplicate or perhaps unnecessary X-ray or Lab procedure, please code "1e".

Every care coordination encounter should have an outcome that "Occurred". Some encounters may have several outcomes that occurred. If you are uncertain how to code the outcome of the encounter, you can code "2o".

IMPORTANT: **If, after all your time and effort spent in CC activities, there remains an unmet need, it is recommended that you list under <u>Outcomes – Occurred</u> as "2n" or "Unmet Needs", and briefly document, ie:**

- **Unable to obtain mental health services**
- **Insurance denied durable equipment request**

Time Spent*							Time Spent
1	2	3	4	5	6	7	
							1 – less than **5** minutes
							2 – **5 to 9** minutes
							3 – **10 to 19** minutes **Check ONLY ONE**
							4 – **20 to 29** minutes **Time Spent Box**
							5 – **30 to 39** minutes
							6 – **40 to 49** minutes
							7 – **50** minutes and greater **(*Please NOTE actual**
							minutes if greater than 50)

Staff	Staff	
		Please document the staff category of the person who completed the Care Coordination activity.
	RN, LPN, MD, NP, PA, MA, SW, Cler	
		It is essential that ALL staff who perform care coordination activities document their work on the CCMT.

Clinical Comp.	Clinical Competence	
	C= Clinical Competence required	**In the opinion of the person filling out each CCMT encounter, did this activity require clinical knowledge or training to complete?**
	NC= Clinical Competence not required	

Initials	Finally, you should put your initials as the last entry for each CC encounter. If the other staff or the billing office, have any questions about your entry, they will know whom to contact for clarification.

Monthly
Charge: Month _____
               Day _____
               Year _____

BILLING OFFICE FORM

Acct #	Patient	Dx Code	MR#	Care Plan Oversight		Phone Calls			Care Conf		Review Records	
				99993743	99993750	99993719	99993727	99993735	99993610	99993628	99993586	99993594

Appendix III: How to Negotiate with Public and Private Insurers
Tools and Strategies

1. The Shared Responsibilities Toolkit: Tools for Improving Quality of Care for Children with Special Health Care Needs (CSHCN) is available on the New England SERVE website www.neserve.org . This publication (2002, 75pages) is designed to focus the attention of health plans on CSHCN. The Toolkit includes an 8-page introductory booklet, and fifteen additional tools that can help plans identify CSHCN and collaborate with families, providers and Title V programs to improve systems of care.

The Shared Responsibilities tools are designed to be easily adapted for use by: any health plan; provider group; purchaser; or state agency working in partnership with health plans.

The Identify section of the Toolkit includes a rationale for why health plans should invest in identifying this population. Four sample tools for identifying children with special health care needs are included, as well as references on how to get additional information and support in using these tools.

The Collaborate section of the Toolkit includes survey formats and resources designed to assist health plans to build partnerships with families, providers, and state organizations that are also involved in providing care for this group of children.

The Improve section of the Toolkit includes examples of best practices at the health plan level, a checklist for health plan policies and procedures that can support serving CSHCN, and a set of measures that can be used to assess a health plan's readiness to focus on this population.

2. **A Pediatrician's Guide to Managed Care, 2nd Edition**
The recent, rapid growth of HMOs, PPOs, and other managed care systems makes it imperative that physicians stay abreast of current issues and policies as this health care delivery model becomes more dominant. This 2001 edition contains new and updated information to assist the pediatrician in understanding how managed care works, how it impacts the pediatrics practice, and how to develop a strategic approach to managed care that is consistent with the physician's own professional goals. You can order this guide on line at: http://www.aap.org/bst/index.cfm?did=15

3. **Coding Resources**

AAP Coding Hotline: 800-433-9016 extension 4022 or aapcodinghotline@aap.org
AAP Coding and Private Sector Advocacy staff of the Division of Health Care Finance and Practice are available to assist pediatric practices with questions on coding, coverage and managed care issues.

AAP Coding Publications:
- Coding for Pediatrics (manual)
- Quick Reference Guide to Pediatric Coding and Documentation for CSHCN. A Companion to Coding for Pediatrics.
- New Quick Reference Guide to Pediatric Coding and Documentation ICD-9-CMFlipchart
- AAP News Coding Corner (monthly column) http://aapnews.aappublications.org/cgi/collection/coding_corner

Newsletters:
- AAP Pediatric Coding Companion
- ICD-9/CPT Pediatric Coder's Pink Sheet
- Pediatric Coding Alert

Online Resources:
- PediaLink Coding Clues:

    Top ten underutilized pediatrics codes http://www.aap.org/visit/top10codes.htm
    CPT Coding Change Request Form (instructions) http://www.ama-assn.org/ama/pub/article/3866-3862.html
    CPT Coding Change Request Form http://www.ama-assn.org/ama/pub/article/3866-3864.html
    ICD-9-CM Coding Change Online Request Form http://www.aap.org/visit/icd-9form.htm

- CMS Web site: Medicare Learning Network (Medlearn) Documentation Guidelines - Evaluation and Management Services http://cms.hhs.gov/medlearn/emdoc.asp
- AAP Committee on Coding and Nomenclature (COCN): http://www.aap.org/visit/coding.htm

You attend an Individualized Education Plan (IEP) meeting for one of your patients. Total time spent in the team conference is 2 ½ hours.

    CODE: 99362 – Team conference (1st 60 minutes)
                99358 – Prolonged services without patient contact (1st hour)
                99359 – Prolonged services without patient contact (each additional 30 minutes)

A mother calls to discuss the possibility of her child having ADHD due to ongoing school problems and the fact that this diagnosis was raised by the teacher who said to see "your pediatrician" about it. Mom is concerned, and the call lasts 35 minutes.

    CODE: 99373 – Telephone call (complex or lengthy)

A mother brings her child with Down syndrome for a 12-month checkup. She is an established patient. In addition to a comprehensive and age-appropriate history and physical examination with anticipatory guidance, the physician discusses issues related to Down Syndrome. This counseling lasts 35 minutes. Consultation reports from the cardiologist and the Individual Family Service Plan from the early intervention program are reviewed. Family requests contact with another family with child with Down syndrome and seeks information about total communication for child to develop skills in sign language, speech, and audition. The visit lasts 55 minutes.

    CODE: 99392 – Periodic comprehensive preventive medicine services visit, established patient, age 1-4 years (1st 20 minutes) Link to V20.3
                99214-25[5] – Office or other outpatient visit, level 4, established patient, appended with modifier –25 (next 35 minutes) Link to ICD9 code for Down Syndrome
                36415 – Collection of venous blood by venipuncture
                90887[6] – Interpretation or explanation of results.