

# PATH (Pacific Asynchronous TeleHealth) System Workload Credit Guidance: TRIPLER AMC

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**SUMMARY:** coding for **TRIPLER AMC (TAMC)** when responding to a **PATH tele-consultation**. Full details at end of summary.

*For specific details regarding HOW to code in PATH please see tutorial entitled "[Submit Work Load Credit Instructions \(Tripler Providers Only\)](#)"*

## **Initial PATH consultation response:**

- E&M code:** Choose 99201-05 (New Patient Codes) using the details documented in the PATH encounter as if you personally performed the service. The -GQ modifier is automatically added for t-med.
  
- Procedure:** If procedures were done at the originating site and interpreted by you, then Select the appropriate CPT code. The -26 modifier will be automatically added (this gives you credit for interpreting the results, but allows originating site to get credit for doing the test/procedure)

## **Subsequent PATH responses for same patient:**

- E&M code:** Choose 99212-15 (Established Patient Codes) using the details documented in the PATH encounter as if you personally performed the service. The -GQ modifier is automatically added for t-med.
  
- Procedure:** Same as during initial PATH response. See above section.

*For both initial and f/u workload credit entered into PATH, coders will create the visit in CHCS/AHLTA locally to ensure RVUs obtained. No further provider action required.*

*Please utilize the PATH buttons "I have reviewed the information above" and "I have reviewed the information in AHLTA" as appropriate to make your PATH charting more efficient and compliant.*

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## **Full Details: Documentation and Coding for TRIPLER AMC for PATH consultations**

Oct 2012

For the Tripler AMC only

Resources: AMA CPT 2012, 2012 MHS Coding Guidelines

### **New Patient (99201-99205)**

When the originating site requests a consultation from Tripler AMC, typically the TAMC provider will see a documented evaluation and management encounter copied into PATH. The TAMC provider is able to use the details documented in this encounter as if it they were the personally performed the service. This is unique to the MHS. In addition, TAMC will likely have to review the patient's record and have discussions with the originating site to get more details in order to make a

medical decision. Below are some documentation tips that will help TAMC providers get the workload credit for the service provided.

|                                  |   |
|----------------------------------|---|
| History                          | Document a history complete with HPI, ROS and past/family social history. This can accomplish this by copying the originating site's encounter, or by referring to the originating site's note. <ul style="list-style-type: none"><li>• "Please see Dr. xxx encounter 9/26/12"</li></ul>  |
| Exam                             | Documentation of exam would be the same as above. <ul style="list-style-type: none"><li>• "Please refer to Dr. xxx exam 9/26/12"</li></ul>  |
| Assessment And Plan              | Documentation of assessment and plan should include the diagnosis and recommendations.  |
| Review and Summarize Old records | Document a summary of any and all additional records reviewed in the patient's AHLTA record, or E&M notes from other specialists. This added detail represents the complicated nature of the service and may support a higher level of service. Be sure to document the source record of the summary. <ul style="list-style-type: none"><li>• "<b>Summary</b> of Dr.X's evaluation dated 9/26/12 is as follows...."</li></ul> |
| Discussion                       | Document any discussion with the originating provider or other specialists in your encounter. This may support a higher level of service as well. <ul style="list-style-type: none"><li>• "<b>Discussed</b> with Dr X the following....."</li></ul>   |

Once your documentation is complete, you can decide what level of service you've provided and select it in the workload credit module in PATH. In order to accurately select the correct level of services, providers must know how to "score" evaluation and management levels based on the documentation. Time based coding for counseling would not be appropriate unless the TAMC provider personally counsels the patient.

### **Subsequent Evaluation and Management Services (99212-99215)**

If the originating site requests additional consultative services for their patient, especially for complicated cases, documentation would be the same as above. However, since the patient is no longer new, established patient E&M codes are required.

In this case it is likely that the remote site will have to review additional records and have additional discussions with the performing providers. In order to select a level of service, the minimum should be documented:

|            |   |
|------------|---|
| History    | An interval history should be documented summarizing any changes since your last evaluation.  |
| Exam       | Exam is not necessary   |
| Assessment | Document the current diagnosis and any complication/comorbidities, any changes or new treatment recommendations, and any additional tests/procedures you recommend. |

### **Procedures and Diagnostic Tests (Modifier -26 professional component)**

Procedures and tests are obviously performed at the originating site, however the specialist at TAMC will usually be asked to interpret and report the findings.

Coding guidelines allow for many procedures/diagnostic tests to be split into two components. The technical component, which is the actual performance of the procedure, is reported by the originating site. The professional component, which is the interpretation and report, is reported by the remote site. Documentation should include the following:

- The place of service where the technical component was performed.
- The interpretation and report of the specialist from the remote site.

### **Prolonged Services Indirect Contact (99358-99359)**

In some of the more extreme cases, evaluating the patient remotely is complicated by the condition of the patient and the amount of medical data and records that must be reviewed. In these cases where that patient’s care is extremely complicated, prolonged services can be report to indicate that it was medically necessary to spend additional time in discussion or reviewing records.

Indirect prolonged services to not have to take place on the same day as you report the consultation, do not have to be face-to-face and do not have to be continuous. This means that if on a given day you spend 30 minutes in the morning reviewing records and another 30 minutes in the afternoon discussing test results with another physician, you can code 1 hour of prolonged services for that day. The following should be documented

- The reason(s) why service was prolonged and *details* describing the reason(s) must be documented in the medical record
- The time spent before and/or after face-to-face patient contact must be documented in addition to details describing the reasons, events, circumstances that took place above and beyond the usual service provided.
  - “X of time spent on indirect **prolonged** services reviewing PATH records...”

**Non-Direct Contact** can be coded alone on a date separate from the base service

**99358** Prolonged evaluation and management service non face-to-face; before and/or after direct face-to-face patient care; first hour;

**99359** Each additional 30 minutes

| Prolonged Services NOT Face-to-Face Outpatient |  |
|--|--|
| Less than 30 minutes                           | No prolonged service   |
| 30-74 minutes                                  | 99358 3 RVU  |
| 75-104 minutes                                 | 99358 and 99359 3 + 1.45 RVU                                     |
| 105 or more minutes                            | 99358 and 99359 for each additional 30 minutes 3 + [n(1.45)] RVU |
| Time does not have to be continuous            |  |

### **Coding PATH services Tripler AMC**

PATH services should not be coded directly in AHLTA. PATH services are coded by walking in and coding the service in CHCS. This will create an appointment in AHLTA as well that should be ignored and should “fall-off” your appointment list at some point. Here are some coding examples:

#### **New Patient Only**

Diagnosis Code: XXX.X (code the appropriate dx for which care/opinion is being sought.

E&M Code: 99201-99205 New Patient (**Do not use codes 99241-99245**)  
-GQ add the modifier GQ to indicate asynchronous telehealth service

#### **Subsequent E&M**

Diagnosis Code: XXX.X (code the appropriate dx for which care/opinion is being sought.

E&M Code: 99212-99215 Established Patient  
-GQ add this modifier to indicate asynchronous telehealth service

#### **E&M with a Procedure**

Diagnosis Code: XXX.X (code the appropriate dx for which care/opinion is being sought.

E&M Code: 99201-99205 New Patient Consultation or  
99212-99215 Established patient  
-GQ add this modifier to indicate asynchronous telehealth service

Procedure code: XXXXXX for the procedure  
-26 add this modifier to indicate the professional component of the procedure.

#### **Procedure Only**

Diagnosis Code: XXX.X (code the appropriate dx for which care/opinion is being sought.

E&M Code: 99499 Unlisted E&M service (place holder)  
-GQ add this modifier to indicate asynchronous telehealth service

Procedure code: XXXXXX for the procedure  
-26 add this modifier to indicate the professional component of the procedure.

#### **Indirect Prolonged Service**

Diagnosis Code: XXX.X (code the appropriate dx for which care/opinion is being sought.

E&M Code: 99358-99359 Indirect Prolonged Services  
-GQ add this modifier to indicate asynchronous telehealth service