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Family Practice Management

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Coding & Documentation

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Documenting modifier -25 services

Q Do I need to write a separate note when I use modifier -25 at a preventive visit?

A CPT does not require that you separately document preventive and problem-oriented services, but it is in your best interest to do so. The CPT descriptor for modifier -25 states: "A significant, separately identifiable evaluation and management (E/M) service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Payers often request records before paying for both services. When there are two separate entries for the services, the work involved for each is more easily defined and the payer is less likely to deny the claim on the basis that the work associated with the problem-oriented service is not distinct from that of the preventive medicine service.

Coding for venipuncture

Q If a patient presents to my office for fasting blood work only, with no E/M service needed, can we charge a 99211 if our nurse performed the blood draw?

A No. You should report the code that most accurately describes the service, and in this situation, that's 36415, "Collection of venous blood by venipuncture," because a venipuncture is the only service provided. This should not be confused with an injection given without direct physician supervision, which *can* be reported with 99211, according to CPT. Note that because Medicare's incident-to billing guidelines require direct physician supervision of services billed with 99211, you cannot bill Medicare (or any other payer that follows Medicare's incident-to guidelines) for an injection given without direct physician supervision unless it was provided by a midlevel provider and reported under his or her own provider number.

Medication refills

Q I often see patients for a follow-up of chronic medical problems after I authorize a single refill of their medications over the phone - just enough so that they do not run out before the visit. I review patients' medication lists prior to authorizing these refills. Can this work influence the level of service of the subsequent office visit, or do I have to repeat the review?

A E/M services are valued to include certain pre-service and post-service work. The Centers for Medicare & Medicaid Services has defined pre-service work as preparing to see a patient, reviewing records and communicating with other professionals when appropriate.

Post-service work includes coordination of care, documentation and telephone calls with the patient, family members or other health professionals associated with the delivery of care to the patient (excluding separately billable services, such as care plan oversight).

A medication refill is generally part of the post-service work, regardless of the amount of time lapsed. However, reviewing the patient's medications counts as evaluating the patient's past history. According to Medicare's *Documentation Guidelines for Evaluation and Management Services*, one of the requirements of a detailed history is that the pertinent past, family or social history be reviewed. If the chart note that was produced at the time of the refill indicates that you reviewed the patient's medications, you can simply document the date of that prior note, e.g., "Medication list reviewed on 2/1/07 with refill request."

Also, your decision to continue current medications based on the results of this encounter should be documented and included when you calculate the medical decision making. Prescription drug management is associated with a moderate level of risk, which may influence the level of medical decision making.

Coding for services in a residency program

Q I am a teaching physician in a family medicine residency program. What is the correct way to use the -GC and -GE modifiers?

A When you are supervising only one resident and you are present during the key portion of a service and immediately available during other parts of the service, use modifier -GC in item 24d of the CMS-1500 form to indicate the service was performed in part by a resident under the direction of a teaching physician.

When the primary care exception applies, use modifier -GE. The primary care exception says the teaching physician does not need to be present in certain situations when the resident provides a level-I, -II or -III service. To be eligible for the exception, the following conditions must be met:

- The resident must have completed at least six months of an approved graduate medical education residency program.
- The teaching physician may not supervise more than four residents at any given time.
- The teaching physician must be in a proximity as to constitute immediate availability.
- The teaching physician must review the care by the resident during or immediately following the service.
- The teaching physician must document the extent of his or her review and direction in the care of the patient.

Your program must attest in writing that these conditions were met, and you must maintain records demonstrating that you qualify for the exception. When billing for this exception, use modifier -GE in item 24d of the CMS-1500 form to indicate the service was performed by a resident without the presence of a teaching physician under the primary care exception.

For the complete list of rules for supervising physicians in teaching settings, see chapter 12, section 100 of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>.

Hospital discharge

Q I saw a patient in the morning as part of my regular hospital rounds. The patient was discharged that afternoon. How should the visit in the morning and the discharge in the afternoon be coded?

A You should use a hospital discharge code to report all services provided to the patient on the date of the discharge, assuming it is not the same date as the admission. Report hospital discharge code 99238 if you spent a total of 30 minutes or less on the discharge, or report 99239 for more than 30 minutes. This is true even if the time you spent on the discharge services is not continuous. You should include the time of the morning visit in the time spent performing the discharge activities later that day including, as appropriate, the final examination, discussion of stay, instructions for continuing care to all caregivers, as well as the preparation of discharge records, prescriptions and referral forms. Because these are time-based codes, be sure to document how much time you spent rendering the services.

Documentation shortcuts

Q When documenting subsequent hospital care, is it acceptable to state in the assessment, "See assessment of prior date," if there is no change in the diagnosis or problems list?

A While referencing a prior note is acceptable, a more direct statement may better support your level of service, such as "No significant changes since the note of the prior date." Not only will this provide more thorough documentation, it could also help you defend yourself in case of a lawsuit.

Coding for diphenhydramine hydrochloride

Q What is the proper code for 50 mg of Benadryl?

A Benadryl is a brand name for diphenhydramine hydrochloride. Use HCPCS code J1200 for up to 50 mg of Benadryl given intravenously or intramuscularly, or Q0163 for a 50 mg dose of Benadryl given orally as an anti-emetic. (See chapter 17, section 80.2 of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf> for special rules that apply under Medicare.)

You can reference the HCPCS codes for drugs online at <http://www.cms.hhs.gov/hcpcsreleasecodesets/downloads/drug2006.pdf>.

Multiple nebulizer treatments

Q What code should I report for providing two nebulizer treatments to an asthma patient in

Do you have a coding or documentation question?

Send it to *FPM* by e-mail, fpmedit@aaafp.org; by fax, 913-906-6000; or by mail, *Family Practice Management*, 11400 Tomahawk Creek Parkway, Leawood, KS 66211-2672. Include your address, daytime phone number and fax number. We cannot respond to all questions we receive, but we will publish answers to selected questions.

the same day?

A Report code 94640 two times, and add modifier -76 to the second code to indicate that you repeated the procedure on the same date.

Editor's note: While this department attempts to provide accurate information and useful advice, third-party payers may not accept the coding and documentation recommended. You should refer to the current CPT and ICD-9 manuals and the *Documentation Guidelines for Evaluation and Management Services* for the most detailed and up-to-date information.

About the Author

Cindy Hughes is the AAFP's coding and compliance specialist and is a Family Practice Management contributing editor. Author disclosure: nothing to disclose. These answers were reviewed by the FPM Coding & Documentation Review Panel, which includes Robert H. Bosl, MD, FAAFP; Marie Felger, CPC, CCS-P; Thomas A. Felger, MD, DABFP, CMCM; David Filipi, MD, MBA, and the Coding and Compliance Department of Physicians Clinic; Emily Hill, PA-C; Kent Moore; Joy Newby, LPN, CPC; P. Lynn Sallings, CPC; and Susan Welsh, CPC, MHA.

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