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Family Practice Management
March 2007, Vol. 14, No. 3, pages 23-5

Coding & Documentation

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Billing for Welcome to Medicare exams

Q I am not getting paid when I bill Medicare for Welcome to Medicare preventive exams. What might I be doing wrong?

A First, remember that the Welcome to Medicare physical (Initial Preventive Physical Examination, or IPPE) is a limited benefit available only to Medicare beneficiaries during their first six months of Medicare Part B coverage and is subject to the Medicare Part B deductible. Check the patient's Medicare card for his or her Part B effective date. If the patient has had Medicare for a longer period of time, the benefit is not available to that patient. Or, if the patient is within the first six months of Medicare coverage, he or she may not have met the deductible, so the Medicare Remittance Advice would indicate the patient owes you for the service.

Second, be sure you are submitting HCPCS code G0344 for the IPPE, not the CPT preventive service codes 99381-99397, when you submit claims for this service to Medicare.

Finally, the electrocardiogram (ECG) portion of this service must be completed prior to billing G0344. Carriers will deny the claim for the IPPE if they have not received a claim for the ECG services. If you provide, interpret and make a report of the ECG in your office, submit code G0366. If you provide the tracing only, submit G0367. If the tracing is done elsewhere and you perform the interpretation and report only, submit G0368.

Note that beginning this year, when you provide an IPPE, you should include counseling regarding ultrasound screening for abdominal aortic aneurysm (AAA) for male patients who have a family history of an AAA or who are ages 65 to 75 years and have smoked at least 100 cigarettes (approximately five packs) in their lifetime. For more information on Welcome to Medicare physicals, see "What's New in Medicare Preventive Benefits," *FPM*, February 2007, and "How to Conduct a 'Welcome to Medicare' Visit," *FPM*, April 2005.

Documenting the ROS and HPI

Q What are the requirements for documenting a review of systems (ROS) and history of present illness (HPI) for pediatric patients? Is it acceptable to omit these components of the history and rely on the exam and medical decision making to determine the level of the visit?

A Because an established patient office visit requires that you perform and document two of the three key components (history, exam and medical decision making), the visit level

could be decided by the extent of the exam and medical decision making alone. A new patient visit, however, requires all three key components.

According to the *Documentation Guidelines for Evaluation and Management Services*, the scope of information documented may vary for some groups (e.g., infants, children, adolescents and pregnant women). Of course, high-quality care dictates that an ROS and HPI be documented, even if the information isn't a factor in determining the level of the service for coding purposes. Because a parent or caregiver who could answer questions related to the ROS and HPI would typically accompany a very young patient to the visit, this information can ordinarily be captured.

Critical care codes

Q Are the critical care codes dependent on the location of the service? For example, can I report a critical care code for patients admitted for chest pain (to rule out acute coronary syndrome) to either the coronary care unit or the telemetry unit?

A The use of critical care codes is not based on the location of service but rather the patient's status at the time of service. These codes are appropriate when the patient is critically ill or critically injured, as defined in the introduction to the CPT manual section on critical care codes: "A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or prevent further life threatening deterioration of the patient's condition."

You should report a critical care code for the time you spend on the unit or floor directly contributing to the treatment of the critically ill or injured patient. For 30 to 74 minutes, report code 99291. For each additional period of up to 30 minutes spent with the patient, report 99292 (e.g., for 110 minutes, report 99291 once and 99292 twice). If you spend less than 30 minutes treating the patient, or if the patient is not critically ill but happens to be in a critical care unit, report the appropriate evaluation and management (E/M) code rather than a critical care code.

Diagnosis coding for vaccines

Q What are the proper diagnosis codes for the human papilloma virus (90649) and the rotavirus (90680) vaccines?

A Code V04.89, "Need for prophylactic vaccination and inoculation against certain viral diseases; other viral diseases." Be sure to include the appropriate immunization administration code from CPT series 90465-90474 on the claim.

Emergent and time-based coding

Q I recently saw a patient in the office and sent her to the phlebotomist (also in our office) for lab work. The patient then had a syncopal episode, and I immediately had to attend to her. I spent a considerable amount of time with the patient, which disrupted the flow of other patients. How should I bill for this?

A All of your E/M services related to this patient on this date should be combined and coded as one encounter. List the code that best represents the reason for the bulk of these services as the primary diagnosis. You should also list additional diagnoses. If the time spent with the patient extended 30 minutes or more beyond the typical time for the level of E/M service being billed, you can report a prolonged services code (99354-99355). (See "Time Is of the Essence: Coding on the Basis of Time for Physician Services," *FPM*, June 2003, for more information on time-based coding.)

Some payers may also reimburse for code 99058, "service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service," for the care you provided that disrupted other scheduled office services. Be sure to document the nature of the services you performed and the time required to handle the emergency.

Screening for immunity

Q As part of our medical school preparticipation exams, all of our students have to get titers drawn to check for immunity to measles, mumps, rubella, varicella and, after being immunized, hepatitis B. Is it appropriate to submit codes V73.2 (measles screen), V73.3 (rubella screen), V73.89 (other viral diseases for mumps, varicella and hepatitis B), along with V70.3 (medical examination for administrative purposes) for these titers?

A Because you are screening for immunity and not for the disease itself, it is more accurate, though less specific, to use code V72.6, "Special investigations and examinations, laboratory examination," to report the laboratory tests, along with V70.3 for the preparticipation exam.

Proper units

Q How many units should I bill for 40 mg of dexamethasone (J1100)? How many for 250 mg of ceftriaxone (J0696)?

A Dexamethasone is billed per 1 mg unit, and ceftriaxone is billed per 250 mg unit. Therefore, you should bill for 40 units when using 40 mg of dexamethasone and one unit when using 250 mg of ceftriaxone.

99204 at an urgent care clinic

Q The physicians in our urgent care clinic routinely code 99203 for services such as urinary tract infections, upper respiratory infections, ankle injuries, etc. I think we might be undercoding some of these services. Assuming we are treating a new patient, when is it appropriate for us to submit 99204?

A Each service you provide should be reported based on the code that best describes the work for that encounter. Code 99204 requires meeting all three key components of the code (comprehensive history, comprehensive exam and medical decision making of moderate complexity), as well as medical necessity for a service of that intensity. CPT describes these services as typically involving problems of moderate to high severity and requiring 45 minutes of face-to-face time with the patient or family. Moderate severity indicates a moderate risk of morbidity without treatment, a moderate risk of mortality

without treatment, an uncertain prognosis or increased probability of prolonged functional impairment.

For otherwise healthy patients, many of the conditions treated might not meet this level of complexity. An internal chart audit may help determine the accuracy of the clinic's current coding practices and whether coding education is warranted. However, if a patient's condition is severe enough that the physician feels it is medically necessary to provide and document the key components of code 99204, this code would be appropriate.

Infusion time + hydration time

Q I recently provided care to a patient with gastroenteritis that involved two hours of infusion time. An anti-emetic was also infused into the line. Can I report both?

A Yes. Use code 90774, "therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug," for the infusion, and report the hydration separately. Because 90774 is an initial infusion code, the hydration code would be reported with the subsequent infusion code, 90761. Remember that time must be documented for these services. You should report any significant, separately identifiable E/M services with modifier -25.

Modifier -32 for immunizations

Q I was told that most of the routine childhood immunizations should be coded with modifier -32 because they are mandated by public health statutes, and they should be reimbursed by payers regardless of whether the parents' policy includes preventive benefits. Is this accurate?

A No. The use of modifier -32 does not force a payer to provide benefits that are not included in the benefit plan. Modifier -32 is intended to report services such as consultations for a second opinion required by a payer prior to a patient receiving a service or for an evaluation performed in an emergency department due to Emergency Medical Treatment and Active Labor Act requirements.

Do you have a coding or documentation question?

Send it to *FPM* by e-mail, fpmedit@aafp.org; by mail, *Family Practice Management*, 11400 Tomahawk Creek Parkway, Leawood, KS 66211-2672; or by fax, 913-906-6010. 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.

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 contributing editor to *Family Practice Management*. 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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