HBO/wound care

Q One of my specialties is HBO/wound care. There are times when the patient has a wound assessment in addition to receiving hyperbaric oxygen treatment. It seems that Medicare often does not pay for the wound assessment (usually coded as 99212 or 99213) and physician-attended HBO on the same day. How do I code or chart differently so that they are recognized as two separate services?

A There are no restrictions under Medicare’s Correct Coding Initiative (CCI) against billing an E&M and hyperbaric oxygen treatment. The modifier -25 should be appended to the E&M service when reporting both. The documentation should support an E&M service above and beyond an assessment that would be conducted prior to treatment. Ask yourself if the E&M would have been necessary had the hyperbaric treatment not been performed. If not, then it is not likely appropriate to report both services.

FIND OUT MORE
Coding Questions Answered
E&M Coding Benchmarks
How to Bill Like a Lawyer

Excisions and closure

Q When billing for skin excisions and closure, how do you determine which is the primary code, and which to modify? Many times the closure costs more than the excision. Would this make it the primary code? When billing for both, is a modifier -59 appropriate?

A First, keep in mind that simple closures (one-layer closures) are included in the excision code. You can code separately for repair by intermediate or complex closures using the -51 modifier. The -59 would only apply if the closure, somehow, was at a different site and part of a totally separate incision. List the higher value procedure first and modify the procedure of lesser value. The modified procedure gets reduced reimbursement, and it’s better to get a percentage cut off a small fee rather than a big one. If you do multiple closures — some to one site, some to another — you can modify those with -59. When choosing between -51 and -59, it helps to think -51: same site, same incision; -59: different site, different incision.

Shared patients

Q Is there a special code/modifier that needs to be used when two physicians see one another’s patients? For example, I may see my associate’s patients on the day he is not in the office.

A There is not a code or modifier required when you see your associate’s patients. You should report the services under your own name and provider number. If services are being provided under a reciprocal billing or locum tenens arrangement, then the services are reported using the primary physician’s provider number and appending the Q5 or Q6 modifier, respectively. Certain
requirements must be met when reporting services under these provisions.

**Part A charges**

**Q** Our provider would like to bill for time spent at the hospital while his patients are having Remacaid or Interferon infusions. We've been using 90780 and 90781, however Medicare states that these are Part A charges. Is there another code we should be using?

**A** You can report the appropriate inpatient E&M code along with prolonged services codes (99356-99357). These are time-based codes and require direct face-to-face contact with the patient beyond the usual service associated with the inpatient E&M code.

**Pre-op physical**

**Q** If a child has a current physical on file and we, as the PCP, need to do a pre-op physical, do we bill with the age-correct physical exam code with the V72.84 diagnostic code, or bill with the exam code with a diagnostic code that would fit the surgery?

**A** When noting the diagnosis, first include the appropriate ICD-9 code from the V72.81-V72.84 series (pre-op testing). Next, list codes representing why the surgery is necessary, and finally, any other conditions.

Note that a physician can report a consultation code for a preoperative clearance if all the requirements of a consult are met, the consult was requested by another provider, and a written report is supplied to the referring physician. The consultation code can be reported even for an encounter with an established patient.

**Global fracture treatment**

**Q** When billing for global fracture treatment, code 27788, can we charge the global fee plus supplies? Please clarify if “supplies” means a short leg cast, code 29405, or does it simply mean charging for two fiberglass cast rolls? Presently, we only charge for the initial treatment 27788 and nothing else. We then charge a cast application charge if the cast needs to be changed during the global period.

**A** Code 27788, like others in the musculoskeletal system section, include the application and removal of the first cast or traction device only, so you do not charge for it. Recasting or replacing the initial cast can be billed, even during the global period, using the appropriate code from the 29000-29590 series.

Please note that the claim may get denied since the payer may mistake it for a resubmission of the original cast application. Include medical documentation to support the recasting when you submit the claim.

You can also, of course, bill for supplies using the correct HCPCS code. The CPT codes describe only the services rendered.

**On-call service**

**Q** Can you please give me a more specific interpretation of CPT code 99052? Can this code be used if the physician is on-call for the weekend or night and receives calls that require medical advice and medication call-in? If not, is there a payable code that can be used? Are the 99050-99058 codes add-on codes only?

**A** Codes 99050, 99052, and 99054 are used in addition to other codes (usually E&M). Code 99052 is defined as “services requested between 10 p.m. and 8 a.m. in addition to basic services.” You might use it to bill if a parent calls in anxious about a child’s fever and the physician agrees to meet him in the office at 11:30 p.m. You’d then bill the E&M and 99052.

Most payers don’t consider a phone-based service applicable.

Here is some further advice from the AAP on this and related codes: www.aap.org/visit/top10codes.htm.

**Primary vs. secondary**

**Q** Our patient has Unicare as primary and Medicaid as secondary coverage. We as an OB/GYN file the global OB Care and Delivery 59400 to Unicare; then when we go to file Medicaid, is it illegal to change the CPT code? Medicaid does not pay for the 59400. They want 59410 (delivery only).

**A** It is legal and appropriate to change the code when it is a requirement by the payer, such as the situation with Medicaid. I would make certain, however, that you have the instructions in writing.

**Stress testing**

**Q** If a physician is doing an exercise stress test on a patient for chest pain, and while the patient is walking on the treadmill they discuss with the physician another problem, can the physician charge for the treadmill and an E&M code for the discussion and treatment of another diagnosis?

I was told that Nuclear Exercise Stress Tests (commonly called Thallium Stress Tests; I believe CPT 78465, 78480, and 78478) are not considered DHS (designated health services); accordingly, we
don’t have to worry about the Stark law. Is that the case?
A For a complete list, by CPT code, of what is considered a designated health service and thus is
91-94.
Q The codes you named are not on this list. The list appears each time the physician fee schedule is
published in the Federal Register.
A Broadly speaking, there are 11 designated health services to which the prohibition applies,
including clinical laboratory services; physical therapy services (including speech-language
pathology services); occupational therapy services; radiology and certain other imaging services;
radiation therapy services and supplies; durable medical equipment and supplies; parenteral and
enteral nutrients; equipment and supplies; prosthetics, orthotics, and prosthetic devices and
supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital
services.

Immunization only
Q When a patient comes in just for an immunization or several immunizations, they are not seeing
the doctor at all. But the nurse will administer the shot. Can we charge a 99211 for the nurse giving
an immunization, or just the immunization code and administer 90471?
A You should not use the 99211 when delivering immunizations even if you are taking routine vital
signs. Verifying that a patient is “OK” for a shot and making sure the patient is OK before leaving the
office are components of the administration code.

Blood pressure check
Q Can I use code 99211 if the patient only came in for a blood-pressure check?
A Here is what the AAFP suggests on blood pressure checks:
“Since there is no separate CPT code for a blood-pressure check, CPT anticipates that such checks
will be coded as 99211 as long as the blood-pressure check is otherwise medically necessary,
involves some evaluation and management of the patient and is not done as part of another E&M or
other service. For example, if a physician tells a patient with hypertension to return to the office
every six months for a blood-pressure check, 99211 should be used because the blood-pressure
check is medically necessary to evaluate and manage the patient’s hypertension.
“On the other hand, if every patient who comes in for a blood draw is automatically given a
blood-pressure check without regard to each patient’s individual medical concerns, 99211 would not
be appropriate because the blood-pressure check may be considered screening — no medical reason
exists for the service and no management of the patient occurs.”

Catheter with intervention
Q When would it be appropriate to bill a catheter placement code (93508, 93510, 93526, etc.) in
conjunction with an intervention (92980, 92982, etc.)?
A Codes 93508, 93510, 93526, etc. are for catheterization procedures. This service is a diagnostic
procedure. The findings from this may result in a therapeutic procedure such as 92980. Both
services are often performed on the same day and at the same setting.

MRIs and denials
Q I need to know what I am doing wrong when I code MRIs. I’ve been using codes 70553, 70544, and
76375. I get denials from insurance companies that say code 76375 is bundled. Is this true or can I
use modifier -59 to get code 76375 paid?
A According to Medicare’s Correct Coding Initiative, you can’t code 70544 and 76375 together.
76375 is considered a component of 70544 and modifiers do not apply.
You can review the CCI edits and get more info about what they mean at:
www.cms.hhs.gov/physicians/cciedits. CPT also notes that there has been commentary about 76375
in CPT Assistant, if you want to buy access to that publication from the AMA. Look for these issues:
Go to www.PhysiciansPractice.com to use the Ask an Expert function to get answers to coding
questions. For more comprehensive services, contact Emily Hill at emily@codingandcompliance.com
or editor@physicianspractice.com.

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