
Complex hospital visit
Q: Can I use 99234 to code for a complex hospital visit?
A: CPT codes 99234 through 99236 can be used only to report hospital services provided to patients admitted and discharged on the same date of service. If this is not the case, use 99231 through 99233.

Repeat services
Q: If I perform the same test several times during a visit - say, an allergy test - do I list the code for the test several times to indicate how many times I did it?
A: If you have performed a service multiple times, it is generally better to indicate the number of tests in the "units box" of the claim form than to list the code multiple times. Otherwise, the payer may think these are duplicate claims. If it is necessary to list the code number multiple times, append the -76 modifier (repeat procedure by the same physician) to all codes after the first.

Lab billing
Q: If I send work to a lab, can I pay the lab directly and charge my private patients for the service myself?
A: Medicare states that the entity performing the service must do the billing. If the physician does the test, then he bills. If it is sent to the lab, then only the lab can do the billing. Other payers may have different rules. You'd have to check with each payer.

Discharge summary
Q: If a patient dies before the rounding physician is actually on the unit, can the rounding physician charge a hospital visit since she will still have to do a discharge summary and other necessary paperwork?
A: No, E&M services cannot be reported unless the patient has been seen. This includes discharge codes. There are no codes for completing a discharge summary only.

Flu shots
Q: How do we code for flu shots?
A: There are four codes that describe the influenza vaccine (90657-90660). In many instances, suppliers are providing the split virus instead of the whole virus. For the split virus, you use code 90657 for children 6 to 36 months of age and 90658 for patients over age 3. The code for the whole virus is 90659. You also would report code 90471 for the administration of the vaccine. For Medicare beneficiaries, the administration code is G0008.

Monitor report for 95951
Q: We bill CPT code 95951 - monitoring for localization of cerebral seizure focus. Our billing service states that they cannot bill without the monitoring report. Is this true?
A: CPT code 95951 is billed for each 24-hour period, so the billing service may be requesting the report to verify the number of hours of monitoring. It may be a requirement of particular payers, or the billing company may want the report on hand for follow-up if the claim is denied. However, there is nothing in the CPT description indicating that a report is necessary to bill the code.

Unspecified diagnosis
Q: What should I do if there is no appropriate diagnosis code to meet the circumstances?
A: If there is no diagnosis code available, you can use "unspecified diagnosis." This code is typically at the end of each section of diagnoses in the ICD-9 manual, so try to use the unspecified code that at least relates to the diagnosis at hand. Depending on the carrier, a claim with an unspecified code may automatically be rejected. Have an appeal letter and the office or operative notes ready to attach to your resubmission. It's not unusual to have an unspecified diagnosis, but it is unusual to have the claim paid without any appeals.
Initial consults
Q: One of our specialists performed an initial consult on a new patient. A few weeks later, the patient came back in need of a consult for a new problem. How do we bill the second visit? Is it a follow-up consult or a second initial consult?
A: CPT specifically states, "If an additional request for an opinion or advice regarding ... a new problem is received from the attending physician and documented in the medical record, the consultation codes may be used again." There are no follow-up outpatient consultation codes. In the outpatient setting, the physician would simply report another outpatient consultation code. For inpatient consultations, "only one initial consultation should be reported by a consultant per admission." Thus, your physician can use a consult code, but not an initial one. He must use a follow-up consultation code or a subsequent hospital care code.

Using modifiers
Q: When using a modifier, such as -25, do you modify the E&M code or the procedure?
A: The -25 modifier is for a "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service." Therefore, the modifier should be attached to the E&M service, and the procedure should stand alone.

Modifier for incident-to
Q: Is there some modifier I should attach to services we have provided incident-to?
A: No. Incident-to services are billed just as if the physician did the service himself. The back of the HCFA 1500 clearly indicates the claim can either designate services provided by the physician or services provided under his supervision.

Educational materials
Q: Can we bill patients or payers for educational materials?
A: There actually is a CPT code for educational materials - 99071. You could check with your payers and see if they will reimburse for it. It is unlikely that they will. You could also ask the payer about having their beneficiaries cover the cost of the materials directly. This is not permissible for Medicare beneficiaries, however. Remember, too, that it may be worth your while to cover the cost yourself, if it cuts down on the number of follow-up calls and other unbillable activities you are forced to handle.

Preventive and sick care
Q: How do we bill for a well visit when the patient also presented a sick complaint?
A: If a patient has received services for both preventive and problem-oriented care on the same day, then you can report both codes with the -25 modifier appended to the problem-oriented E&M service. It is not appropriate to report preventive medicine visits under a problem-oriented code, nor is it correct to increase the level of service to account for the preventive portion of the encounter. This is particularly true for Medicare, since comprehensive preventive exams are not covered. Most other payers will deny problem-oriented E&M services with an ICD code indicating preventive care. Therefore, be sure that the diagnosis for the problem is linked to the problem-oriented E&M service on the claim form.

Casting codes
Q: Can we bill for treating a fracture and for an initial casting on the same visit or does the fracture code automatically include payment for the cast?
A: The casting codes - 29075, for example - are not used for the initial casting if a fracture care code is also reported. They should be used only for subsequent recasting.

Modifiers -51 and -80
Q: In the past we have charged 50 percent for multiple procedures when billing with modifier -51 and 20 percent for the services of an assistant surgeon billed under modifier -80. I have heard lately that most practices are billing 100 percent even under modifier -51 and 45 percent to 50 percent for the assist. What is the common standard in today's market? What are the pros and cons?
A: It depends on the market. Payers typically reduce the payment for all procedures beyond the primary one. Therefore, the highest valued procedure is listed first and the lesser-valued ones are listed in descending order of value. It is advisable to bill all procedures at their full fee and allow the payer to determine the discount for multiple procedures. Otherwise, the fee may be reduced twice. For example, a physician may reduce his or her $100 fee for a given procedure by 50 percent and list $50 on the claim form. The payer may also reduce that fee by another 50 percent. Thus, the physician receives only $25. Assistant surgeons typically are paid between 20 percent to 30 percent of either the insurer's allowable or of the primary surgeon's fee, whichever is less. Medicare pays 16 percent of the allowable for services that allow assistants at surgery. If you know the allowable amount for assistant surgeons, as you do with Medicare, you can bill the allowable amount and not
worry about adjustments. Generally, a percentage (usually 30 percent to 40 percent) of the established fee for the surgery is reported since it is difficult to know the exact payment for all payers. The disadvantage to billing higher charges is that you will have larger write-offs. This can be handled by most billing systems without difficulty. Be aware that an increasing number of CPT codes are pre-discounted and exempt from the -51 modifier; CPT coding books will indicate this. Largely, these are procedures that are performed only as part of another procedure.

**Finger-stick machine**

Q: My office purchased a finger-stick Protime machine to monitor the many patients we have on Coumadin. The manufacturer of the machine has advised me to bill CPT code 85610W (which barely covers the cost of the $5 Protime strip) and a low-level office nursing visit 99211 (with proper documentation). We now bill Medicare patients in this fashion. I currently do not offer this service to patients with other types of insurance, due to the hassle of referral forms and pre-approval for the test and the fact that most plans require a copay for the office visit. However, I would like to monitor all my Coumadin patients with this machine. Can I bill patients with insurance a nominal fee and have them sign a waiver that states I will be billing them directly and will not file a claim with their insurance company?

A: There are a couple of issues that need to be considered if you bill non-Medicare patients out-of-pocket. First, most commercial contracts will not allow you to bill patients directly for covered services. A medically necessary Protime and office visit would be considered a covered service. In addition, you would now be billing Medicare more than you do others for the same service. This is a legal problem. You also should not waive an office visit charge to non-Medicare patients as long as you bill Medicare for the visit. It would be best to bill all patients in the same manner for the service.

"Get acquainted" visits

Q: When a patient comes for a "get established" visit with no serious complaints we are coding as an annual exam. Are there separate procedure charges for the breast exam, prostate exam, etc.? Or are these global in the E&M code? If so, should modifier -25 be used anywhere?

A: There is no CPT code for a "get acquainted" visit, so you'll need to perform a true well-male or well-female check in order to bill for these. If you are, the likelihood is that all of the services (e.g., DRE) are indeed included in the E&M. That would exclude lab services, which you would bill separately, but don't need a modifier. Modifier -25 is limited to noting a "separately identifiable" E&M service - which is used when you have a separate diagnosis; therefore, you need to point out that you've actually performed two services during one encounter (because the patient has two distinct needs).

**Psychotherapy E&M**

Q: What is the difference between a 90807 and a 90806? If a patient is not on medication, but I, as a physician, am continually considering this with the patient, is it reasonable to code 90807?

A: Here's what CPT (or the authors, AMA) define as the difference: 90807 involves "medical evaluation and management services." They define this as "evaluation and management services involve a variety of responsibilities unique to the medical management of psychiatric patients, such as medical diagnostic evaluation (e.g., evaluation of comorbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations." 90806 is without medical E&M/psychotherapy only. There is a citation that the AMA issued a clarification of these codes in their November 1997, July 1999, and March 2001 "CPT Assistant." We don't carry back issues of the newsletter, but you can order them from the AMA at: www.ama-assn.org/ama/pub/article/8183-6997.html. Based on your services and your documentation of such, you'll have to make a judgment call as to whether you meet the definition above in order to justify the billing of it. The newsletters may give examples that help you decide, so it might be worth getting those.

**Endoscopy codes**

Q: Can we code a 43239 with a 43249? I'm not sure if 43239 is included in 43249.

A: CPT guidelines permit the reporting of multiple endoscopy codes as appropriate. Codes 43239 and 43249 describe distinctly different procedures and should not be bundled by the payers. Both codes however include an upper GI endoscopy and payment adjustments should be expected for the duplicative portion. The issue becomes one of bundling - that is, is one code "bundled" in another by the payer? With the exception of Medicare, each carrier (Cigna, Aetna, Humana, etc.) has its own edits regarding bundling. There is no "national" bundling book for us to check in other than Medicare's Correct Coding Initiative (CCI). Under the CCI, these procedures are not bundled. I suggest that you report both services and monitor the EOB. If they are denied, I would appeal by
referring to the distinct nature of the services and the CCI. It is helpful to have distinct ICD-9 codes (if appropriate) for the services to support the need for both of them on the same patient.

**Place of service**

Q: A patient came into the ER for an emergency removal of a foreign object. We billed outpatient for place of service and the procedure code was 43247. Since we did not have an authorization, we need to send a correct claim with place of service as ER. We do not have a CPT code for the procedure for ER, but we did change the diagnosis to ER 935.1. I don't know how else to bill. Do you have any answers?

A: The CPT and ICD-9 codes do not change based on the place of service. If you are not being paid, you should contact the payer to determine the reason. Changing the CPT code would not be appropriate unless the payer has a unique (local) code that it requires. Visit [www.PhysiciansPractice.com](http://www.PhysiciansPractice.com) to ask questions of coding and compliance expert, Emily Hill; just click on the Ask an Expert button. Every question will be answered within three business days and sent directly to your e-mail box. Some questions and answers may be chosen for publication in Physicians Practice.

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