Part B Insider (Multispecialty) Coding Alert

Frequently Asked Questions: 5 Ways to Perfect Your Cold and Flu Claims

Hint: E/M codes and vaccines may not always go hand-in-hand.

The cold weather is looming, which means you're likely to see an uptick in the number of patients presenting with colds or the flu, as well as other autumn maladies. Read on to ensure that you can answer these common coding questions to ensure that you don't lose any reimbursement in the coming months.

Know When E/M Is Billable With Vaccine

Question 1: I have been reporting flu vaccines along with E/M codes, but some insurance companies have been denying them even if I append modifier 25. What am I doing wrong?

Answer: According to Correct Coding Initiative (CCI) edits, E/M office or inpatient codes are bundled into the vaccine administration codes 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered), 90471 (Immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; 1 vaccine [single or combination vaccine/toxoid]) 90473 (Immunization administration by intranasal or oral route; 1 vaccine [single or combination vaccine/toxoid]) and G0008 (Administration of influenza virus vaccine).

The modifier indicator for most of these bundles is "1" which indicates that you can separate the codes using an appropriate modifier such as 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service). However, the exception to this rule is code 99211. The modifier indicator for the edits that bundle this code with the vaccine administration codes above is "0." That means CCI edits won't allow you to report 99211 for the same patient on the same date as a vaccine administration.

Note: You should not report an E/M visit code if your doctor only records a brief history, checks the patient's vitals, and rules out any contraindications to the administration of the vaccine. Such a minimal assessment is likely to be considered part of the vaccine administration itself, which may explain why the CCI edits do not allow you to report 99211 in addition to a vaccine administration code. In such a case, you will only report the administration code and not an E/M code. You can report an E/M service with a vaccine administration code if and only if the E/M service was significant and separately identifiable from the vaccine administration as reflected in the physician's documentation of the encounter.

As noted, you need to have proper documentation to justify the medical necessity and to prove that your physician actually provided a distinctly separate E/M service while also giving the patient a flu shot. In such a case, a different diagnosis code may help support separate payment of the office visit code. In any case, ICD-9 code V04.81 (Need for prophylactic vaccination and inoculation against other viral diseases; influenza) is linked to the code for the influenza administration as well as the CPT® code for the influenza vaccine itself, which you should also report. If you are using ICD-10 codes, you will have to use Z23 (Encounter for immunization) instead of V04.81.

Know the Medicare-Specific Supplies

Question 2: Our administrator said that flu shot supply coding rules are different for Medicare patients. Can you explain how?

Answer: If your physician is providing the influenza vaccine to a Medicare patient, you will have to look specifically into the brand of vaccine rather than just noting that you administered an Influenza shot. The reason is that the codes you

use for supply may be different depending on the vaccine used. So when reporting the vaccine for Medicare patients, you should choose from the following codes:

- Q2034 -- Influenza virus vaccine, split virus, for intramuscular use (Agriflu)
- Q2035 -- Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use [Afluria]
- Q2036 -- ...[Flulaval]
- Q2037 -- ...[Fluvirin]
- Q2038 -- ...[Fluzone]
- Q2039 -- ...[not otherwise specified]

Differentiate Runny Nose Codes

Question 3: What diagnosis code should I use for rhinorrhea? The only reference I can find is 349.81, but that doesn't sound right.

Answer: You should report rhinorrhea -- otherwise known as a runny nose -- with 784.99 (Other symptoms involving head and neck), according to the 2014 ICD-9 manual.

Tool: Your instinct is correct regarding 349.81 (Cerebrospinal fluid rhinorrhea). CSF rhinorrhea results from a defect or injury to the skull that allows fluid to leak into the nasal passages -- a much more serious condition than a runny nose.

Know How to Control Nosebleed

Question 4: We see a lot more nosebleeds in the winter months due to the dry environment. If the physician has to stop the nosebleed, should we report 30901?

Answer: Although your first instinct might be to report 30901 (Control nasal hemorrhage, anterior, simple [limited cautery and/or packing] any method), don't move too fast. Submitting 30901 could be overcoding in some situations or undercoding in others.

If a patient reports to the physician with a nosebleed and the physician stops the bleeding with standard, minimal methods such as ice or pressure, you should choose an E/M code. For instance, an established patient reports to your office with a nosebleed. The physician performs an expanded problem focused history and examination, and then applies pressure to the right nostril for two minutes. The bleeding stops, and the physician discharges the patient. You would report an E/M code such as 99213 for the entire encounter.

If your physician's documentation indicates that the encounter involved more extensive stoppage techniques -- such as using silver nitrate sticks or a small amount of cautery or packing for an anterior bleed-- choose 30901 for the service, along with any E/M service that the physician might provide. You'd need a procedure note, separate from the E/M documentation, if applicable, showing that the bleed was stopped with packing or cautery.

In extreme cases, your physician might also perform a complex anterior nosebleed repair. These encounters involve more complicated methods to treat, such as nasal packing and possibly a rhinorocket or epistaxis balloon. If so, you would code the procedure with 30903 (Control nasal hemorrhage, anterior, complex [extensive cautery and/or packing] any method).

The average national payout for 30901 is $97.44 for a non-facility service (based on the 2014 national average Medicare conversion rate of $35.8228). Code 30903 pays $210.64 for non-facility service, based on the same Medicare conversion rate.

Bottom line: Being able to report 30903 can boost your reimbursement, but be careful when reporting this CPT® code. Always ensure that your physician's documentation supports whatever code you submit, especially when you're separating the E/M code and the minor procedure in order to report both services.

Question 5: My pulmonologist put both bronchitis and upper respiratory infection as the diagnoses. Can I code both or

only the bronchitis?

Answer: You should code both diagnoses since the physician stated both. Bronchitis would cover the 490-491 codes in ICD-9. For URI, you should report either 465.0 (Acute laryngopharyngitis), 465.8 (Acute upper respiratory infections of other multiple sites), or 465.9 (Acute upper respiratory infections of unspecified site).

Bronchitis is an inflammation of the airways (called bronchi), and is usually caused by infectious agents such as bacteria or viruses. An upper respiratory infection (URI) includes any infectious-disease process that usually involves the respiratory system. The upper respiratory tract includes the:

- nose
- nasal cavity
- ethmoidal air cells
- frontal sinuses
- maxillary sinus
- larynx
- trachea.

Physicians sometimes use the term bronchitis along with upper respiratory infection since the patient may have started with a URI that developed into bronchitis, but because the bronchi are found in the lungs, bronchitis is actually a lower respiratory infection or a lung condition.