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Part B Insider (Multispecialty) Coding Alert

Summer Coding Quiz Answers: Are You A Summer Coding Whiz, Or Will You Be Facing Summertime Coding Blues? Check Out the Answers Below

Tally your score with the following three solutions.

Determine whether you're ready for summer coding cases by checking your answers to our summer coding quiz on page 123 against these three solutions. You may also want to share this summer coding advice with your office staff to ensure that everyone is on the same page when it comes to coding these scenarios.

Tick Removal Offers Coding Challenge

Answer 1: Often, coding for tick removals comes down to one question: is a tick venomous or nonvenomous? Ticks can infect a patient, but they don't have venom like an ant mite would. That information lets you choose "bite: insect, nonvenomous," which directs you to the site-specific superficial injury codes (910-919). If you had incorrectly classified a tick as venomous, you would have ended up with a nonspecific diagnosis of 989.5 (Toxic effect of other substances, chiefly nonmedicinal as to source; venom).

Choose 910-919's third digit based on the bite's location. For instance, a bite on the scalp goes to 910.4 or 910.5 (Superficial injury of face, neck, and scalp except eye ...) dependent on whether it is infected (5) or not (4).

Lyme Exposure: If the physician has a concern about Lyme exposure, then use the appropriate V code to indicate exposure. Report Lyme exposure with V01.89 (Contact with or exposure to other communicable diseases). You may also assign an E code to explain the injury's cause, such as E906.4 (Other injury caused by animals; bite of nonvenomous arthropod).

Not sure how all these diagnoses line up? Sequence this example: A patient presents with a tick on her scalp. The physician evaluates the spot, asks questions about Lyme disease-related symptoms, removes the tick using probing tweezers, and decides to hold off on antibiotic treatment since the patient has no signs of Lyme disease.

The claim could be coded with 910.4 (... insect bite, nonvenomous, without mention of infection) for the bite and E906.4 (optional) to indicate an injury from a nonvenomous arthropod.

If the patient later returned and the physician diagnosed the patient with Lyme disease from an infected tick bite, you would report only the disease (088.81, Lyme disease). It's typically a given that it came from a tick.

To code for the CPT® service, you'd report the appropriate E/M code, such as 99211-99215 or 10120 for removal requiring opening the skin to remove a foreign body, depending on the documentation.

Get Ready to Treat Sunburns

Answer 2: You'll need to answer the "local treatment" question before you can nail down the correct sunburn treatment code. Red skin -- even an area that might technically be "burned" -- doesn't automatically lead to reporting a burn treatment code. If your staff doesn't administer treatment specifically for the sunburn, you may only report an E/M code (99201-99215) for the check.

Example: A 67-year-old patient presents with sunburned shoulders and back. After examination, the physician determines the burn is superficial and will heal on its own in a few days. He instructs the patient to wear his shirt while outdoors. You'll report the appropriate E/M code such as 99212 for an established patient or 99201 (Office or other

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outpatient visit for the evaluation and management of a new patient ...) for a new patient.

If, however, the patient in the example above has a more severe burn, his care might qualify for code 16000 (Initial treatment, first degree burn, when no more than local treatment is required). Check whether you treat the burn with topical medication (anesthetic) or other options. This code has a zero day global period, and has an RVU of 1.98, which translates into about $67.27 in payment.

Example: If the physician diagnoses a first-degree burn and treats it as such--for example, with a compress on the area--you can typically report the E/M code as well as 16000. Append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code in this situation.

Nail Down Substitute Physician Coding

Answer 3: The general rule, particularly for Medicare payers, is to use modifier Q6 (Service furnished by a locum tenens physician) when billing for substitutes. Locum tenens reporting guidelines govern all services provided to Medicare patients by a substitute physician. The modifier simply tells the payer that a locum tenens physician provided the services -- a one-way exchange between physicians.

Rule of thumb: You must append modifier Q6 to every procedure code on a claim for a substitute physician. But remember, you should still send the bill out under the regular physician's name.

For instance, when a substitute physician provides a level-two E/M for an established patient, you would bill 99212-Q6 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making) under the primary physician's National Provider Identifier (NPI).

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