Part B Insider (Multispecialty) Coding Alert

YOUR PART B QUESTIONS ANSWERED

Hang Up On Using Telephone Codes Within 7 Days

Question: Our ob-gyn office does backup for a midwife practice.

They referred a patient to us to receive the H1N1 vaccine. Patient arrived and had a lot of questions. My nurse answered all her questions and administered the vaccine. After the patient left, she called and spoke with our nurse numerous times (at least five times) about the vaccine. We charged a phone consult (which is the patient's responsibility to cover). Should we have billed 99211 with the vaccine charges?

Answer: No, you should not have billed 99211 (Office or other outpatient visit ...). The administration code (90470, H1N1 immunization administration [intramuscular] [intranasal] including counseling when performed]) includes patient counseling. Code 99211 requires a face-to-face encounter for the evaluation and management of a problem.

You can no longer use the telephone codes (99441-99443, Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment ...) for follow-up to a problem seen in the office within seven days of the visit. CPT guidelines state: " ... if the telephone call refers to an E/M service performed and reported by the physician within the previous seven days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure."

Verify Anatomic Location for Golfer's Elbow

Question: What is the appropriate ICD-9 code for golfer's elbow?

Answer: The ICD-9 2010 index points you to 726.32 (Enthesopathy of elbow region, lateral epicondylitis) for golfer's elbow. But some providers also may use the term to refer to medial epicondylitis issues (726.31, Enthesopathy of elbow region, medial epicondylitis). So check your documentation for the precise anatomic location before settling on a code.

Note that tennis elbow, a more familiar term, refers to lateral epicondylitis (726.32). Other injuries that might hinder an athlete's game are medial epicondylitis (726.31), enthesopathy of elbow (726.30, ...unspecified), and olecranon bursitis (726.33, ... olecranon bursitis). All of these "enthesopathies" refer to disorders of peripheral ligamentous or muscular attachments.

Consider Incident To For Follow Ups

Question: One of our nonphysician practitioners saw a patient during a follow-up visit -- what is required in order for us to report these services to Medicare as incident-to the internist?

Answer: To qualify for incident-to, the internist must have seen the Medicare patient during a prior visit and established a clear plan of care. If the non-physician practitioner (NPP) is treating a new problem for the patient, or if the internist has not established a care plan for the patient, then you cannot report the visit incident-to.

Important: When meeting the requirements for established plan of care follow up, if the internist does not directly supervise the NPP, the incident-to rules do not apply. Direct supervision means a supervising physician must be immediately available in the office suite. The supervising physician, however, does not necessarily need to be the same physician that established the patient's care plan.

Example: An established Medicare patient reports to the internist on March 13. The internist performs an E/M service, diagnoses the patient with pneumonia,writes prescriptions and, as part of plan of care, asks the patient to return in one week to follow up with the nurse practitioner. On March 21, the patient returns to the internist for a follow- up visit. The NPP evaluates the patient's signs and symptoms and performs an examination. The nurse practitioner recommends finishing the course of antibiotics and returning for follow up in three weeks.

In this example, you can report the NPP's service incident to the physician. On the claim, report the appropriate level E/M code. Don't forget to file the claim under the supervising internist's national provider identifier (NPI) rather than the NPP's NPI; this ensures you 100 percent pay for the E/M, while coding under the NPP's NPI results in 85 percent pay for the service.

Don't overlook that the NPP has the proper credentials to perform incident-to services. The NPP must be "licensed by the state under various programs to assist or act in the place of the physician," according to the Medicare Benefit Policy Manual, chapter 15.

Best bet: Check your state and local Medicare regulations for NPP qualifications. If the NPP does not meet one or both sets of guidelines, don't bill incident-to for her services.

Learn New Use for KX Modifier Question: I've heard that Medicare has a new way to override gender-specific edits, when appropriate, based on patient circumstances. Are we supposed to use a specific modifier?

Answer: For Medicare Part A, institutional billing, hospital, or ambulatory surgical centers, you will use new condition code 45 (Ambiguous gender category) with claims that may be denied "due to sex/diagnosis and sex/procedure edits," according to recent MLN Matters article MM6638.

You'll use this code when "the service performed is gender specific (i.e., services that are considered female or male only)," the article notes. "This claim level condition code should be used by providers to identify these unique claims and to allow the sex-related edits to be processed correctly by Medicare systems and allow the service to continue normal processing," the MLN Matters article spells out.

Additionally: For Medicare Part B payments -- payments to physicians and non-physician practitioners -- you will append modifier KX (Requirements specified in the medical policy have been met) to all services billed.

This informs your payer that the services are gender specific, and your patient meets the requirements to allow normal processingof these claims.

Example: A trans-sexual patient, who has undergone psychological and surgical services to convert him from a male gender to a female gender, has a urological examination (prostate) and a prostate-specific antigen (PSA) blood test. Although he is legally a female, he still requires prostate monitoring for possible malignant prostatic degeneration. Billing this patient for a male disease will often lead to denials of payments based on inconsistency of sexual gender. Speaking with the carrier before billing and appending modifier KX will be helpful in receiving proper reimbursement.

To read more about new condition code 45, go online to the CMS Web site at www.cms.hhs.gov/MLNMattersArticles/downloads/MM6638.pdf.