Part B Insider (Multispecialty) Coding Alert

YOUR PART B QUESTIONS ANSWERED: Coding for Supplies Depends On Place of Service

Question: Can I use 99070 to report the use of supplies at our office?

Answer: The AMA and Medicare already factor essentials into a code's values on the physician fee schedule. If you're doing a procedure in the office that requires tools, surgical trays, or other supplies, the reasonable expectation is that you will be using equipment and that those costs have been accounted for in the price's procedure.

The site of service differential in the Medicare fee schedule, which pays more for this procedure when done in the office versus a facility, is meant to include these supplies and services.

For example, if the doctor does a biopsy in the office (such as 11100, Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion), he will use equipment to do it, and he may need to close the biopsy site with simple closure by suture or bandage. These supplies are considered bundled into the biopsy code and are not separately billable.

Exception: Private payers that do not follow the Medicare fee schedule might not include supply costs in their payments. In these cases, you could be paid for the item(s) by reporting 99070 (Supplies and materials [except spectacles], provided by the physician over and above those usually included with the office visit or other services rendered [list drug, supplies, or materials provided]) for items that incur a cost in the office (POS 11). Check with the commercial payer to determine if this service is separately billable.

Use Current Diagnosis to Support E/M Visit

Question: A new patient sees the doctor because of shoulder problems. The physician schedules an MRI and the patient returns the following week to discuss the findings. The physician had already reviewed the films and goes over them in depth with the patient. He also administered a shoulder joint injection to help relieve the patient's pain.

What diagnosis should we report with the E/M service to reflect the amount of time the physician spent reviewing films and counseling the patient and to distinguish it from the injection?

Answer: Select a diagnosis based on your provider's documentation, such as rotator cuff tear (840.4, Sprains and strains of shoulder and upper arm; rotator cuff [capsule], or 727.61, Rupture of tendon, nontraumatic; complete rupture of rotator cuff) or calcifying tendonitis of the shoulder (726.11).

Include that diagnosis with the appropriate E/M code for your physician's service (99211-99215, Office or other outpatient visit for the evaluation and management of an established patient ...). 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.

Also report 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]) with 719.41 (Pain in joint; shoulder region) for the shoulder injection.

No Global Isn't an H&P Billing Green Light

Question: I understand that Icannot bill for an H&P if there is a global because it is included in the surgery. Can we bill for an H&P if there is no global period for the procedure or service?

Answer: You cannot separately bill for the history and physical (H&P) your neurologist performs even for a procedure with a zero-day global period or no global period. Even when there is no global period associated with a code, there is an inherent E/M built into the fee for the code and as such this H&P is not a billable service.

Bottom line: Every procedure code's global package includes the preoperative work performed by the physician before the procedure or service. Therefore, unless the E/M service is a significant and separately identifiable E/M, you cannot bill it.

Unless the office visit is medically necessary to re-evaluate a condition, such as diabetes or hypertension, that may affect the proposed procedure, you should not bill for the visit that's strictly for obtaining pre-procedure information. Your pre-op H&P becomes an "administrative" H&P, especially if your physician made the decision to perform the procedure at another encounter.

Exception: Some payers, however, will cover preoperative consultation (99241-99245, Office consultation for a new or established patient, which requires these three key components...) for patients for whom the payer considers it medically necessary (such as patients who have a comorbidity that may complicate a surgery). Check with your payer to see if it has a coverage policy on this matter. If you feel the visit is medically necessary, your primary or first diagnosis for the preoperative visit should be in the V72.8x (Other specified examinations) series, such as V72.84 (Pre-operative examination, unspecified).

Link Modifier Q6 to Locum Tenens Claims

Question: We hired a locum tenens while our physician was on maternity leave. Do we code the same for the replacement physician as for a full-time doctor?

Answer: Private payer rules may vary, but for Medicare patients, you should append modifier Q6 (Service furnished by a locum tenens physician) to all the temporary doctor's Medicare claims and bill under the national provider identifier (NPI) of the physician the locum is replacing.

You must append this modifier to every procedure code on a Medicare claim for a substitute physician. You'll send the bill out under the regular physician's name, but modifier Q6 alerts Medicare that a locum tenens physician provided the services.

Watch for: Medicare has a 60-day limit for a locum tenens physician, and your practice may not extend this, according to Medicare Claims Processing Manual, Chapter 1, Section 30.2.11, where you'll find additional details (www.cms.hhs.gov/manuals/downloads/clm104c01.pdf). Medicare does allow physicians to cover for absences of longer than 60 days by hiring multiple substitute physicians, each one to cover only the maximum allowable period of 60 days.

Private payers vary: Before using modifier Q6 for a non-Medicare patient, check with the commercial payer. Some will follow the Medicare locum tenens guidelines, but you should not assume that all commercial payers will want modifier Q6. Private payers' rules regarding substitute physicians can differ from Medicare's.

Definition: Locum tenens describes a one-way exchange between physicians, in which your doctor retains a substitute physician to take over the practice temporarily and pays the substitute physician a fixed amount per diem. Reasons for bringing in a substitute may include illness, pregnancy, vacation, or continuing medical education.