

# INTERNAL MEDICINE CODING ALERT

The practical monthly adviser for ethically optimizing coding reimbursement and efficiency for internal medicine practices

Vol. 6, No. 3 (Pages 17-24)

March 2003

## What's Inside

Put Your Thinking Cap on When Coding Diagnosis for Dementia Assessments.....	19
You Won't Skip a Beat If You Code Cardiac Components.....	20
You Be the Coder.....	20
• Diagnosis Is Not Listed In ICD-9	
Carefully Monitor Your ICD-9 Codes for Heart Test.....	21
Reader Questions.....	22
• Patient Receives After-Hours Care	
• Use Unlisted-Procedure Code for Dead Patient	
• Use Documentation to Code Lesion Size	
• Office Visit Precedes Nursing Home Admission	

## Don't Let Dementia Assessment Coding Send You Over the Edge

Many internists are confused about how to code dementia assessments for their geriatric patients because CPT does not provide a code for these encounters, but you can secure some reimbursement for your time by reporting the individual services performed during these comprehensive assessments.

“This is one of the areas that you will not get reimbursed for all the work involved,” says **Jan Rasmussen, CPC**, president of the Eau Claire, Wis.-based Professional Coding Solutions. “You must bill for the components as provided.”

Internists are increasingly being asked to provide these assessments, usually at the urging of family members who are concerned that an elderly patient's forgetfulness or other symptoms may affect his ability to care for himself.

The codes you use to report a geriatric dementia assessment will vary depending on the problems of the patient, but typically an assessment will include a comprehensive examination, mental/cognitive assessments, possible magnetic resonance imaging (MRI), computed tomography (CT) scanning or other imaging scans, and care planning after diagnosis, Rasmussen says.

You will likely code an initial visit for the evaluation and a follow-up visit after test results come back. Most internists will refer the patient out for some of the testing.

### Use E/M Code for Initial Assessment

The first step in a geriatric dementia assessment is typically a doctor's examination. The physician will perform a physical, take a history and conduct a family interview to ascertain the behaviors — such as forgetfulness or difficulty with daily tasks — that prompted the assessment.

“Be sure to document signs, symptoms and reasons for the workup,” Rasmussen says.

Code this visit using the appropriate office/outpatient E/M code. “The level you select is going to depend on what the patient's problems are,” Rasmussen notes.

If the patient's only health problem is forgetfulness, you will likely use a lower-level code, Rasmussen says.

Most elderly people, however, have other health problems — such as vascular disease, diabetes, hypertension, and often a history of stroke or heart attack — and the physician must consider these health issues when assessing them for dementia, says **John E. Morley, MD**, director of the Division of Geriatric Medicine at Saint Louis University School of Medicine and editor of the *Journal of Gerontology: Medical Sciences*.

When a patient has multiple problems, the doctor will typically spend one to one-and-a-half hours completing the assessment — and the visit's complexity may

### MISSION:

To help busy internal medicine coding professionals and practices code claims correctly and achieve optimum ethical reimbursement. To provide clear, useful internal medicine-specific CPT and ICD-9 coding advice.

To bring readers practical, useful coding techniques from the nation's expert coders and MDs. To serve as a guide through the increasingly complex outpatient reimbursement system, and to help our readers reduce denials and receive the reimbursement their services deserve.

*Internal Medicine Coding Alert* is an independent publication and does not accept advertising. Our only allegiance is to YOU, our reader.

substantiate billing the highest-level E/M for an office visit (99205 for new patients or 99215 for established patients), Morley says.

The doctor performs a battery of tests — such as a mini-mental status exam and a gait and balance assessment — at this initial visit, in addition to the history, physical and family interview, Morley says.

“We roll all of that into the E/M,” Morley says, because these tests do not have their own CPT codes.

The doctor often refers the patient out to a psychologist for neurocognitive testing in areas such as cognitive ability, memory, visual/spatial ability and language, says **Phen Liem, MD**, a board-certified geriatrician who is professor of geriatrics at the University of Arkansas for Medical Sciences in Little Rock. Coders typically report these assessments using a code from the central nervous system assessments/tests section of CPT — for example, 96115 (*Neurobehavioral status exam [clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning] with interpretation and report, per hour*). Be sure to note that most payers reimburse for this code only when mental-health professionals perform extensive assessments — and medical doctors cannot use it for mini-mental status exams.

## Document Signs and Symptoms for Testing

The internist may order a variety of diagnostic tests at the initial encounter, depending on the patient’s symptoms. Typically, these include blood tests, an MRI scan, and possibly a positron-emission tomography

(PET) scan, Morley says. These tests will help pinpoint whether the patient’s symptoms are caused by Alzheimer’s disease (331.0), vascular dementia (290.4x), or another disorder.

When ordering tests to diagnose dementia, physicians must be careful to “document in the medical record the signs and symptoms associated with this,” or the payer may not deem the test medically necessary, Rasmussen cautions.

Be sure that your diagnosis codes support the particular tests you are running. When billing Medicare, check your local medical review policies (LMRP) to determine which ICD-9 codes are covered diagnoses for the tests you run. For example, in Florida, First Coast Service Options considers diagnoses from the 290.0-290.9 range (*Senile and presenile organic psychotic conditions*) and the 330-334.9 range (*Hereditary and degenerative diseases of the central nervous system*), which includes Alzheimer’s disease, as covered diagnoses for a CT scan of the patient’s brain. But the carrier does not cover 290-290.9 for a brain MRI. On the other hand, Medicare carrier Palmetto GBA says that in Ohio and West Virginia, both 290.0-291.2 and 331.0-334.9 are covered diagnoses for an MRI of the brain.

## Use Proper E/M Code for Follow-Up Visit

Patients usually return for a second visit to learn the results of testing and to get counseling on the next step for treatment. Morley typically bills a level-four E/M code for this visit (99214). Although this visit is not as complex as the initial assessment, Morley says he often spends

### CONTACT INFORMATION

Readers are invited to submit comments, questions, tips, cases and/or suggestions for articles on any subject related to internal medicine coding, reimbursement and/or compliance.

**Mail:** 2272 Airport Road S., Naples, FL 34112

**Phone:** (800) 508-2582; **Fax:** (800) 508-2592

**Editor:** Deanna Thompson  
(dthomp4913@aol.com)

**Consulting Editor:** Kathy Pride, CPC,  
CCS-P; Bruce Rappoport, MD, CPC

#### **Executive Editor:**

Chris Owens (c Owens@medville.com)

#### **Managing Editor:**

Erin Lang Bonin, PhD (erinlb@medville.com)

**President:** Samantha Gardiner  
(sam@medville.com)

#### **Director of Sales and Customer Relations:**

Andrew Roedig (andrew@medville.com)

#### **Circulation Director:**

Rhonda Vore (rhonda@medville.com)

#### **Teleconference Director:**

Carolyn Weld (carolyn@medville.com)

*Internal Medicine Coding Alert* (ISSN 1522-7480) (USPS # 019-158) is published monthly by The Coding Institute. ©2003 The Coding Institute LLC. All rights reserved.

POSTMASTER: Send address changes to *Internal Medicine Coding Alert*, 2272 Airport Road S., Naples, FL 34112  
Periodical Postage Paid at Naples, FL, and additional offices.

**Web:** www.codinginstitute.com **Customer Service:** service@medville.com **Discussion Group:** www.coding911.com

Rates: USA: 1 yr. \$248; 2 yrs. \$476 (\$20 savings); 3 yrs. \$694 (save \$50). Bulk prices available upon request.  
Credit Cards Accepted: Visa, MasterCard, American Express, Discover.

*CPT codes, descriptions and material only are copyright 2003 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS Restrictions Apply to Government Use.*

*Internal Medicine Coding Alert* is independent and not affiliated with any organization, HMO, vendor, or company. Reasonable attempts have been made to provide accuracy in the content. However, of necessity, examples cited and advice given in a national periodical such as this must be general in nature and may not apply to any particular case. Further, medical coding is part science, part art; even experts sometimes differ. Also, clinical and other circumstances may differ between cases and thereby affect coding. Thus, neither the publisher, editors, board members, contributors nor consultants warrant or guarantee the information contained herein on coding or compliance will be applicable or appropriate in any particular situation. For information tailored to your specific circumstances, consult a qualified professional.

This newsletter has been approved by the American Academy of Professional Coders for up to 10 CEUs. Granting of prior approval in no way constitutes endorsement by the AAPC of the program content or the program sponsor. Subscribers interested in obtaining CEUs for reading *Internal Medicine Coding Alert* should call the AAPC at (800) 626-2633.



The Coding Institute also publishes the following Coding Alert newsletters. Call (800) 508-2582 for free samples:

<b>Coding Monthlies:</b>	General Surgery	Otolaryngology	<b>Coding Quarterlies:</b>
Anesthesia and	Neurology	Pathology/Lab	Allergy
Pain Management	Neurosurgery	Pediatrics	Pain Management
Cardiology	Ob-Gyn	Physical Med. & Rehab	<b>Other Newsletters:</b>
Emergency Medicine	Oncology	Pulmonology	Medical Office Billing and Collections Alert
Family Practice	Ophthalmology	Radiology	Medical Office Nurse
Gastroenterology	Orthopedics	Urology	Medical Office Receptionist

extensive time explaining the diagnosis and counseling the patient and family concerning the next steps. E/M rules permit you to base your code selection on time if you spend more than 50 percent of a face-to-face visit in counseling or coordinating care for the patient.

The physician may suggest that the patient see the nurse practitioner or a social worker for help in managing factors affecting the patient's well-being, such as remembering to take her diabetes medications. If these workers are on staff in the office, you may be able to bill these sessions with CPT codes 96150-96155, created in 2002 for *health and behavior*

*assessment/intervention* by psychologists, social workers and other health professionals, such as nurses or nurse practitioners, Rasmussen says. CPT designed these codes to address bio-psycho-social factors affecting patients with physical health issues.

Be sure to do your homework before using the 96150 series to make sure your Medicare carrier accepts these codes. The Florida carrier — First Coast Service Options — lists the 96150 series as noncovered.

Also note that physicians cannot use these codes but instead should use E/M codes when they provide similar services, the CPT manual states. □

## Put Your Thinking Cap on When Coding Diagnosis for Dementia Assessments

Diagnosis codes used in coding dementia assessments can have a major impact on patients' treatment options — and your reimbursement.

Physicians need to take care in selecting diagnosis codes and be sure to code all appropriate diagnoses to justify the complexity of the encounter, says **John E. Morley, MD**, director of the Division of Geriatric Medicine at St. Louis University School of Medicine and editor of the *Journal of Gerontology: Medical Sciences*. For example, if the patient has multiple diseases — such as diabetes and hypertension, in addition to the dementia — they will be part of your assessment of the patient and should be used as diagnoses, he says.

You should only code diagnoses that apply to the patient, but Morley notes that you will generally secure higher reimbursement with a diagnosis of Alzheimer's disease (331.0) than with a more general cognitive complaint.

That's because ICD-9 classifies Alzheimer's disease as a medical diagnosis, while it considers senile dementia (290 series) a mental disorder — and Medicare reduces the allowable amount for mental-disorder codes to 62.5 percent of the allowable amount for medical codes. Because Medicare reimburses 80 percent of that reduced amount, your reimbursement for E/M services tied to a senile dementia diagnosis drops to 50 percent of the Medicare allowable — compared to 80 percent for a medical code, such as Alzheimer's disease, says **David S. Geldmacher, MD**, an associate professor of neurology at the University of Virginia in Charlottesville.

Although Medicare says the other 50 percent is the patient's responsibility, in practice many doctors don't receive the additional co-pay because of the difficulty of the collection process, says Geldmacher, one of the co-authors of a November 2002 story on coding for dementia

and related disorders in the *Journal of the American Geriatrics Society (JAGS)*.

Physicians and coders should check with their carriers to determine their reimbursement policies for the 290 series because individual carriers and private payers may have different interpretations, Geldmacher says. If your payer reimburses the 290 series at the lower mental-disorder rate, you should recoup the normal 80 percent CPT code reimbursement if senile dementia is your secondary diagnosis — behind, for example, hypertension, the *JAGS* story notes.

For treatment reasons as well as reimbursement reasons, the physician should make a strong effort to pinpoint the cause of the dementia, says **Wayne C. McCormick, MD**, a board-certified internist and geriatrician who is an associate professor of medicine at the University of Washington department of medicine in Seattle.

Physicians can make a fairly certain Alzheimer's diagnosis by ruling out other causes of dementia, McCormick says. The second most common cause after Alzheimer's disease is vascular dementia (290.4x), a form of dementia resulting from inadequate blood flow to the brain caused by arteriosclerotic disease. Other forms include dementia related to alcohol abuse.

An older patient who has dementia but no history of stroke or alcoholism and has a normal or close-to-normal computed tomography (CT) or magnetic resonance imaging (MRI) scan statistically has more than a 90 percent probability of having Alzheimer's, McCormick notes. "It's a diagnosis of exclusion," he says.

When a patient fits the above scenario, physicians should make the diagnosis of Alzheimer's disease, McCormick says, not just because it may increase reimbursement but also because drugs can be prescribed that help patients with this diagnosis improve their cognitive processes and their functionality. Many insurance companies will not cover a patient's prescription for cholinesterase inhibitors — which show promise in treating Alzheimer's disease — unless the doctor has made that specific diagnosis, Geldmacher says. □

# You Won't Skip a Beat If You Code Cardiac Components

When coding a heart test for a patient, you may feel as if you're being tested yourself as you puzzle over the many codes in the cardiography section of the CPT manual. But you'll pass with flying colors if you use a global code when appropriate — and remember that the other codes in the series are not add-ons but individual services.

The cardiography section (93000-93278) includes codes for three tests that internists sometimes use to determine the health of a patient's heart: Holter monitoring, stress tests and electrocardiograms (EKGs). The series for each of these tests begins with a global code — including hookup, scanning analysis and interpretation/report — followed by codes that break out components separately.

Coders sometimes try to append modifier -26 (*Professional component*) to the global code to show that the physician provided only some of the services, but doing so will result in a claim denial, says **Kathy Pride, CPC, CCS-P**, HIM applications specialist with QuadraMed based in San Rafael, Calif.

“These codes are unusual CPT codes because you can't separate out the professional component of the code by appending a -26 modifier,” Pride says.

Instead, if you perform only some of the services described in the global code, bill just those components — rather than coding the global.

## Know Your Holter Monitor to Code Properly

Holter monitor testing is the most confusing code series, Pride says. Patients typically undergo this testing when they have complained of heart palpitations or flutter, and the doctor wants to monitor the patient's heart constantly over a

24-hour period so he or she can see and analyze the irregular rhythms. For 24 hours, the patient wears a beeper-sized box that measures and records heart activity.

The coder's first dilemma is choosing the correct code series to use, because CPT shows three series (93224-93227, 93230-93233, and 93235-93237) that describe slightly different Holter monitor techniques.

“To know which one to use, you have to know which technology you have,” Pride says.

The primary difference among the codes is in how the heart rhythms are recorded, stored and analyzed:

- 93224 — *Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation*
- 93230 — *Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation*
- 93235 — *Electrocardiographic monitoring for 24 hours by continuous computerized monitoring and non-continuous recording, and real-time data analysis utilizing a device capable of producing intermittent full-sized waveform tracings, possibly patient-activated; includes monitoring and real-time data analysis with report, physician review and interpretation.*

If you are not sure which code describes your office's machine, ask the doctor what type of equipment he uses, says **Michele Zimmerman, CPC**, coder at the four-physician Florida Heart and Vascular Associates in Tampa. You can also check with the company providing the Holter monitor to determine which code criteria it meets, Pride says.

You need to distinguish between the types of monitors both for coding accuracy and for reimbursement reasons, says **Bruce Rappoport, MD, CPC**, a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for RCH Healthcare Advisors LLC, a Fort Lauderdale, Fla.-based healthcare consulting company.

The 93230 series is the highest-paying series, with reimbursement at about \$161 nationally, not adjusted for region, for the global — almost \$10 more than the 93224 series global, at \$152. The 93235 series is the lowest-paying, with reimbursement for the global at about \$117 nationally.

## You Be the Coder

### Diagnosis Is Not Listed in ICD-9

**Question:** *How should I code reactive airway disease without coding asthma? I can't find a listing in the ICD-9 manual.*

West Virginia Subscriber

**Answer:** Test your coding knowledge. Decide how you would code this situation before turning to page 22 for the answer.

## Bill Only for Components Provided

You should bill the first code in the series (for example, 93224) for Holter monitor testing if your doctor performed all of the described services, which include hooking up and removing the monitor, analyzing the scan, and reviewing and interpreting the results. If the doctor performed only some of those services, however, you will bill only for the individual services provided.

All three of the Holter monitor code series break out the individual components separately. Let's say your office monitored the patient using the equipment described in 93224, but the physician did not do the scanning analysis. Commonly, physicians will have an outside company perform that technical component, Pride says. In that scenario, you would code 93225 for the recording, hookup and removal of the Holter monitor and 93227 for physician review and interpretation. The scanning company would bill on its own for the analysis.

"The simplest way to look at it is: He who provides the service, bills and collects," Rappoport says.

## Don't Stress Over Stress Tests

Stress tests are another heart procedure that internists sometimes order for their patients. This test measures how well the heart handles exertion and can show if blood supply is reduced in the arteries leading to the heart. The patient typically walks on a treadmill or pedals a stationary bike at increasing speeds while hooked up to heart monitoring equipment. He or she then undergoes monitoring again after the test for heart rate, blood pressure and other vital signs.

The exercise stress test is set up the same way as the Holter monitor codes, with a global followed by breakouts of the components:

- 93015 — *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or*

*(Continued on next page)*

## Carefully Monitor Your ICD-9 Codes For Heart Tests

Be sure your diagnosis code supports medical necessity for the heart test you code.

"If you want to know why your electrocardiogram was denied, look first to your ICD-9 code," says **Bruce Rappoport, MD, CPC**, a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for RCH Healthcare Advisors LLC, a Fort Lauderdale, Fla.-based healthcare consulting company.

Sometimes the physician will inadvertently code using a noncovered diagnosis, Rappoport says. The doctor may note that the patient has hypotension (458.0-458.9), or low blood pressure, for example, which is not a covered diagnosis for an electrocardiogram (EKG) in Florida, says **Michele Zimmerman, CPC**, coder at the four-physician Florida Heart and Vascular Associates in Tampa. In that scenario, the coder should seek out the doctor and ask about signs and symptoms that prompted the order for an EKG.

"The coder should ask the doctor, 'Was the patient having chest pain? Or shortness of breath? Or is he going on a medication that can affect the heart? Or is the EKG for a pre-op?'" Zimmerman says.

Those are all examples of conditions that may be covered diagnoses for an EKG — and often, one of them is noted in the patient's record, Zimmerman says.

If you don't find a covered diagnosis in the physician's documentation, however, you should not change the diagnosis code to a covered one, because that would

constitute fraud. You must code based on the physician's documentation.

When selecting a diagnosis code, be sure to check your local medical review policies to determine covered diagnoses in your state for EKGs, Holter monitoring and stress tests, Zimmerman says.

Carrier interpretations of covered diagnoses vary from state to state. For example, Cahaba — the Medicare carrier in Iowa and South Dakota — considers 345.00-345.91 (*Epilepsy*) a covered diagnosis for Holter monitor testing, but First Coast Service Options, the Florida carrier, does not. In Florida, 423.1 (*Adhesive pericarditis*), 423.2 (*Constrictive pericarditis*), 424.0 (*Mitral valve disorders*) and 425.0-425.9 (*Cardiomyopathy*) are covered diagnoses, while they are not with Cahaba in Iowa and South Dakota.

Many coders also have questions about how to code the diagnosis if the test shows no problems with the heart.

"A lot of people are confused and think that if you have a normal test you have to code it as a screening," says **Kathy Pride, CPC, CCS-P**, HIM applications specialist with QuadraMed based in San Rafael, Calif.

That is incorrect. "If the diagnostic test did not provide a definitive diagnosis or was normal, the testing facility or the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study," according to Section 15021 of the *Medicare Carriers Manual*.

For example, a patient who came to the office with chest pain has an EKG, which is normal, and the internist determines that the chest pain is likely due to gastroesophageal reflux disease (GERD). The primary diagnosis code for the EKG would be chest pain (786.5x). □

pharmacological stress; with physician supervision, with interpretation and report

- 93016 — ... physician supervision only, without interpretation and report
- 93017 — ... tracing only, without interpretation and report
- 93018 — ... interpretation and report only.

Most internists' offices will never use 93015 because they typically do not have the equipment to conduct stress tests in their offices, Rappoport notes. Usually, they will send a patient to the hospital or to a cardiologist for a stress test.

If the internist sends the patient to the hospital for the stress test, sometimes the internist will also go to the hospital to monitor the test. Use 93016 in this scenario. If the internist doesn't supervise the stress test but interprets the results, use 93018. If the doctor does both, you should code both 93016 and 93018.

## Electrocardiograms Follow Pattern

An EKG is a routine heart test that internists often use as the first test for a patient having symptoms of heart disease. The physician attaches electrodes to the patient's chest and uses them to record heart rhythms. Unlike stress tests, internists often perform EKGs in their offices.

If you remember the pattern for the above codes, choosing a CPT code for an EKG is simple. Use the global code 93000 (*Electrocardiogram, routine ECG with*

*at least 12 leads; with interpretation and report*) when the patient has the EKG in the office and your physician interprets the results. If the doctor sent the patient elsewhere for the EKG but performed the interpretation and report, use 93010 (... *interpretation and report only*). You likely won't use the other code in this series, 93005 (... *tracing only, without interpretation and report*), because it is used when a facility performs the EKG but does not provide the physician report and interpretation. □

## READER QUESTIONS

### Patient Receives After-Hours Care

**Question:** *A Medicare patient knocked on the door on a Friday when the office was closed. He was worried that his blood pressure was elevated. The physician took a history and performed an exam, counseled the patient and prescribed blood-pressure medication. We coded the visit with 99213 and 99050. Is that right?*

South Carolina Subscriber

**Answer:** Code 99050 (*Services requested after office hours in addition to basic service*) is listed as a "Status B" code in the Medicare fee schedule. This means that CMS has not assigned any relative value units (RVUs) to this service, and it is always considered a bundled service. So Medicare will not pay for this code. Because Medicare is the payer in the scenario described, you may bill only the E/M code.

You should note that some commercial insurance companies, however, do reimburse for 99050. Physician practices will often negotiate this code as part of their fee schedule with commercial payers.

□

### Use Unlisted-Procedure Code for Dead Patient

**Question:** *Our doctor went to a patient's home for a home visit and found the patient dead. He did a brief physical exam to make the official determination. There is no charge for "pronouncement of death" that I am aware of, but can a regular home visit be charged because he probably took a brief history from a family member and did an exam?*

Texas Subscriber

**Answer:** You are correct that there is no code for the "pronouncement of death." The physician, however, is still

## You Be the Coder

(Question on page 20)

### Diagnosis Is Not Listed in ICD-9

**Answer:** Sometimes, you will not find a particular disease or condition — such as reactive airway disease — listed in the ICD-9 manual. In those cases, you need to know the underlying or precipitating cause of the condition to select the proper diagnosis code. Check the physician's documentation for notes about the cause of this disease. If the reactive airway disease is from acute bronchitis or bronchiolitis, then 466.x (*Acute bronchitis and bronchiolitis*) would be appropriate. This series includes bronchospasm. If the only symptom the doctor noted is wheezing, then you could use 786.07 (*Wheezing*). If the physician notes either allergic or asthmatic bronchitis, then you could use the code for asthma, unspecified (493.9x). □

providing a service and may bill for it, just as the physician bills for a discharge when the patient dies in the hospital.

Because the patient was dead when the physician arrived, the service provided probably won't meet the requirements for using the home services codes (99341-99350). For a new patient, the physician service must include the three key components (history, exam and medical decision-making). If the patient was established in the practice, you would need two of the three key components to use the home services codes.

The physician likely did not take a history or use medical decision-making of sufficient complexity to meet the code requirements in the scenario described. So your best choice is to code the visit using 99499 (*Unlisted evaluation and management service*). When using 99499, you must file a paper claim, include a cover letter explaining the service provided and attach the medical record to the claim.



### Use Documentation to Code Lesion Size

**Question:** *The new CPT guidelines for excision of a benign or malignant lesion state that you should select the CPT code based on the size of the lesion plus margin. Should I get this information from the physician documentation or can I take it from the pathology report?*

Kentucky Subscriber

**Answer:** You should use the lesion and margin measurements from the physician documentation when reporting the 11400 series (*Excision — benign lesions*) and the 11600 series (*Excision — malignant lesions*). If the physician does not note the measurements, ask her to add an addendum to the documentation that includes the size of the lesion.

If the physician did not record the size at the time of surgery and cannot provide you with this information, you can use the size recorded in the pathology report. But that may cost the practice money it should have received in reimbursement. Lesions shrink when placed in formaldehyde. Because the codes are based on size and are separated by only 0.1 centimeter, you may be forced to select a lower code — and lesser reimbursement — if you use the size recorded in the pathology report. (For more information on the 2003 lesion coding changes, see “Keep Your Ex’s and In’s Straight When Coding Lesion Removal” in the January 2003 issue and “CPT 2003: Lesion Measurement, Finger Sticks Top List of Changes for Internists” in the December 2002 issue of *Internal Medicine Coding Alert*.)



### Office Visit Precedes Nursing Home Admission

**Question:** *Can I bill for an office visit for an established patient and then bill for a nursing home admission the next day if the doctor does the history and physical the next day? My doctor is asking me if this is possible. I've always bundled it into the nursing home admission.*

Missouri Subscriber

**Answer:** The answer hinges on the reason for the office visit. If the physician is performing portions of the nursing home admission history and physical in the office on the day prior to the admission and completing the nursing home admission process on day two, then the office visit is bundled into the nursing home admission code (99303). But if the patient visited the office the day before nursing home admission for management of an acute problem or a chronic illness, you can bill the office visit separately using the appropriate E/M code (99212-99215).



### Does Flu Shot Establish a Patient?

**Question:** *We gave a flu shot a couple of months ago to the wife of a patient we were seeing that day. She asked the doctor for a flu shot because her husband is immunosuppressed and she did not want to give him the flu. The wife was not our patient at the time. We billed only for a*  
*(Continued on next page)*

Subscriber  
Discount Offer

## Medical Office HIPAA Alert

### Stay on the Right Side of HIPAA

Have you put off preparing for HIPAA? Will you be ready to comply by April 2003? If not, you should act fast. Subscribe to the new 8-page monthly newsletter that will give you practical information you can use: expert advice, timely tips, and answers to questions from readers in practices just like yours.

**Topics Include:**

- How to handle business leaks
- HIPAA-savvy quizzes
- HIPAA violations: How to avoid them
- Patients' rights: Do's and Don'ts

AD0303

100% No-Risk  
Money-Back  
Guarantee

Regular price: \$229 Your Price: \$179!

Call to order your  
discounted copy today:  
(800) 508-2582

To start your subscription today, call (800) 508-2582.

The Coding Institute • 2272 Airport Road S. • Naples, FL 34112  
(800) 508-2582 • Fax: (800) 508-2592 • E-mail: service@medville.com • Web: www.codinginstitute.com

flu shot using 90658 and 90471, and no care was documented other than the flu shot (temperature and notation of arm injected). Yesterday, we saw the wife for her first visit with us to establish her as our patient. What is the correct way to bill her visit with us yesterday — new or established?

Illinois Subscriber

**Answer:** The key to answering your question is to know who administered the flu shot to the patient's wife: the physician or a nurse.

Both the AMA and CMS define a new patient as one who has not received any professional services from the physician or another physician with the same specialty in the same group within the previous three years. The *Medicare Carriers Manual* section 15502(A) further defines "professional services" as any "face-to-face service provided by the physician."

So, if the nurse provided the flu shot, the wife did not receive a "face-to-face service" from the physician, and you can code her current visit as a new patient encounter (99201-99205). This is similar to the scenario when practices set up flu-shot clinics during flu season. At these clinics, the physician does not order or directly supervise administration of the flu shot. If a person receiving a flu shot from a nurse at a clinic decides later to establish as a patient in the office, you can bill for a new patient visit.

Everything changes, though, if the physician administered the flu shot to the patient. He has provided a face-to-face service, so you would have to code the visit by the patient's wife to establish service as a visit from an established patient (99212-99215).

Although Medicare is clear regarding how it differentiates between new and established patients, this is a "gray" area of coding because individual carriers may interpret this scenario differently. You may wish to ask your payer for its interpretation to be certain you are coding correctly.

— *Answers to You Be the Coder and Reader Questions were provided by Kathy Pride, CPC, CCS-P, HIM applications specialist with QuadraMed, a national healthcare information technology and consulting firm based in San Rafael, Calif.; and Bruce Rappoport, MD, CPC, a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for RCH Healthcare Advisors LLC, a Fort Lauderdale, Fla.-based healthcare consulting company.* □

## Editorial Advisory Board

**Jean Acevedo, LHRM, CPC, CHC**  
Senior Consultant  
Acevedo Consulting Inc.

**Brett T. Baker**  
Senior Associate of Regulatory  
Affairs  
The American College of Physicians

**Joel Brill, MD**  
American Gastroenterological  
Association  
Representative, CPT Editorial Panel  
Advisory Committee

**Catherine A. Brink, CMM, CPC**  
President, Healthcare Resource  
Management Inc., N.J.

**Kathryn Cianciolo, MA, RRA,  
CCS, CCS-P**  
Coding Consultant  
Meridian Resource Company LLC,  
Wis.

**Ian S. Easton, PhD, FACMPE**  
Past President, American College of  
Medical Practice Executives  
Department Head, Applied  
Technology, Coastal Georgia College

**Mary I. Falbo, MBA, CPC**  
President, Millennium Healthcare  
Consulting Inc.

**Marti Geron, CPC, CMA, CM**  
Coding and Reimbursement Manager  
The University of Texas  
Southwestern Medical Center at  
Dallas

**Cathy Klein, LPN, CPC**  
Director of Regional Network Services  
Cardinal Health Initiatives LLC

**Glenn D. Littenberg, MD, FACP**  
Member, Physician Reimbursement  
and Coding Committee, American  
College of Physicians, American  
Society of Internal Medicine,  
Member, AMA CPT Editorial Panel

**Janet McDiarmid, CMM, CPC,  
MPC**  
CEO, McDiarmid Consultants LLC  
Past President  
American Academy of Professional  
Coders  
National Advisory Board

**James A. McNally**  
Third-Party Coding Specialist  
Health Care Consultant Services,  
N.Y.

**Ron Nelson, PA-C**  
Clinical Practitioner  
Reimbursement Policy Analyst  
President, Health Services  
Associates, Mich.  
Past President, American Academy of  
Physician Assistants

**Judy Richardson, MSA, RN, CCS-P**  
Senior Consultant  
Hill & Associates, N.C.

**Jim H. Stephenson**  
President, North Central Medical  
Management, Ohio

### SUBSCRIBE TODAY!

Online Version  
Available

**Yes!** Enter my one-year subscription to *Internal Medicine Coding Alert* monthly newsletter for just \$248.

**Extend!** I already subscribe. Extend my subscription for one year at only \$248.

**Subscription Version Options:** (check one)  Print  Online\*  Both\* (Add online version FREE)

E-mail \_\_\_\_\_

\* Must provide e-mail address if you choose "online" or "both" option to receive issue notifications

**Payment Information:**  Check enclosed: \$ \_\_\_\_\_ (payable to The Coding Institute)

Bill my credit card  MC  VISA  AMEX  DISC Exp. date \_\_\_\_\_

Acct. # \_\_\_\_\_ Signature \_\_\_\_\_

Bill me (please add \$15 processing fee for all billed orders)  P.O. \_\_\_\_\_

Name \_\_\_\_\_

Title \_\_\_\_\_

Office \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

*Internal Medicine  
Coding Alert*  
2272 Airport Road S.  
Naples, FL 34112  
Call: (800) 508-2582  
Fax: (800) 508-2592  
E-mail:  
service@medville.com

*To help us serve you better, please  
provide all requested information.*