

CODING & DOCUMENTATION

Cindy Hughes, CPC

Using medical assistants to scribe with EHRs

Q Our practice recently adopted an electronic health record (EHR) system. One physician who has lost productivity due to the time it takes him to complete documentation is requesting that his medical assistant act as a scribe for his services. Is this permissible?

A It is permissible for a physician to ask a medical assistant or other ancillary staff familiar with medical terminology and documentation to act as a scribe. Whether the documentation is paper-based or electronic, it must clearly reflect the name and credentials of the person acting as a scribe in addition to those of the physician. The physician should attest to the fact that the documentation represents an accurate record of his or her words and actions during the visit (for example, “I personally performed the services documented here and agree that the documentation accurately represents these services and the decisions I made. Jane Smith, MD”). If

the scribe to sign into the EHR under the physician’s user ID and password, as this would give the scribe access to the physician’s electronic signature. If your EHR system is flexible enough to allow for shared documentation and attestation, and your practice has the necessary resources, it might make sense to enable your physician to work with a scribe.

ICD-9 codes and combination vaccines

Q What ICD-9 codes should be reported when a child receives multiple combination vaccinations? Must we report each component when no ICD-9 code describes the vaccine combination?

A If the vaccines are administered in conjunction with a well-child visit, your primary diagnosis code should be V20.2, “routine infant or child health check.” You may list the codes for the vaccines as secondary codes if required by the payer. If a code for a specific combination vaccine does not exist in ICD-9, report V06.8,

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the scribe *performs* the review of systems (ROS) and the past, family and social history (PFSH) rather than simply documenting it, the physician must also indicate in the note that he or she specifically reviewed the ROS and PFSH and made changes or additions as needed. (The history of the present illness must always be performed by a physician or midlevel provider, as appropriate.)

Working with a scribe may be more complicated when using an EHR, in part because the physician may not allow

which represents “need for prophylactic vaccination and inoculation against combinations of diseases, other combinations.”

ICD-9 currently includes codes for seven different combination vaccines (V06.0-V06.6), so be sure to consult the 2011 version of ICD-9 for specific codes.

Same-day discharge and readmission to another hospital with transfer to another doctor in the same group

Q How should we bill Medicare when a patient is discharged by Dr. A from Facility A and immediately transferred to Facility B, where he is admitted to inpatient status by Dr. B, who is in the same group as Dr. A but works at a different location that uses the same tax identification number?

A If admission to the second facility took place on the *same date* as discharge from the first, you should bill a subsequent hospital visit code with the level of service based on the combined work of the two physicians. Because they work in the same group, they are

About the Author

Cindy Hughes is the AAFP’s coding and compliance specialist, a contributing editor to *Family Practice Management* and co-author of *FPM’s* Getting Paid blog (<http://blogs.aafp.org/fpm/getting-paid>). Author disclosure: nothing to disclose. These answers were reviewed by the *FPM* Coding & Documentation Review Panel, which includes Robert H. Bösl, MD, FFAFP; Marie Felger, CPC, CCS-P; Thomas A. Felger, MD, DABFP, CMCM; David Filipi, MD, MBA, and the Coding and Compliance Department of Physicians Clinic; Emily Hill, PA-C; Kent Moore; Joy Newby, LPN, CPC; P. Lynn Sellings, CPC; and Susan Welsh, CPC, MHA.

treated as the same physician for purposes of payment.

If the discharge and admission did not occur on the same date and the transfer was between different hospitals, the first physician could bill the discharge management code and the second physician could bill an initial hospital care code, according to Medicare instructions.

99211 visits

Q Is it necessary for a physician to be present for a 99211 service?

A The presence of a physician is not always required. Although physicians can report 99211, the code exists to allow practices to report services rendered by other clinical staff members. According to CPT, the staff member may communicate with the physician, but the physician's direct involvement is not required.

Medicare's requirements on this point are slightly different: While the physician's presence is not required at each 99211 service involving a Medicare patient, the physician must have initiated the service as part of a continuing plan of care in which he or she will be an ongoing participant. In addition, the physician must be in the office suite when each service is provided.

According to Medicare and most third-party payers, incidental services should generally be reported under the name and billing number of the physician or other professional in the office suite when the service is provided.

High-dose influenza vaccine

Q What administration and ICD-9 codes should I report for providing the new high-dose influenza vaccine, 90662, to a Medicare patient?

A You should report code G0008, "administration of influenza virus vaccine." Use ICD-9 code V04.81 when providing the influenza vaccine unless you also provide a pneumococcal vaccination on the same date. When providing both vaccines, report code V06.6. The influenza vaccine may be billed to Medicare once per influenza season (twice in a calendar year).

Editor's note: While this department attempts to provide accurate information, some payers may not agree with our advice. You should refer to the current CPT and ICD-9 coding manuals and payer policies. **FPM**

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