

CODING & DOCUMENTATION

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Billing for forms completion

Q Can I bill patients for the time it takes me to complete forms for sports physical examination clearance or disability when the patients aren't being seen in the office at the same time?

A Yes. You can bill patients for forms completion on a cash basis. The amount charged can range from \$10 to \$25, depending on the nature of the form. You should also check with your payers to determine whether they would view the services as "bundled" and, therefore, not separately billable. See "Should You Charge Your Patients for 'Free' Services?" *FPM*, July 2004, <http://www.aafp.org/fpm/2004/0700/p43.html>.

Visual acuity testing for children

Q Can I bill separately for visual acuity testing (99173, "Screening test of visual acuity, quantitative, bilateral") performed during a child's preventive exam?

A Yes. The CPT guidelines for preventive medicine coding state that vaccines, immunizations, ancillary studies involving laboratory, radiology or other procedures, or screening tests identified with a specific CPT code should be reported separately from the preventive code.

Time thresholds for preventive counseling

Q What are the guidelines regarding how much time the physician must spend providing preventive counseling? Why is time specified for these codes when physicians exceeding the time cannot code units of service for additional payment?

A In general, unless there are code- or code-range-specific instructions or guidelines to the contrary, CPT states that the total time requirement is satisfied once the 50 percent threshold of time has been met. For example, the time element of code 99401, "Preven-

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tive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes," is met when the physician spends at least eight minutes of face-to-face time counseling the patient.

The intent of including time in the code descriptors is to give providers some indication of how much physician work is expected in order to report the service and to prevent reporting of the service when an otherwise trivial amount of time is spent on it.

Home sleep monitoring

Q My office has started providing home sleep monitoring for sleep apnea. Can we bill the code 95806, "Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg. Thoracoabdominal movement)" with diagnosis code 327.23, "Obstructive sleep apnea, adult/pediatric," prior to receiving the results of the sleep testing?

A Sleep studies are typically covered by Medicare if the patient has symptoms of obstructive sleep apnea. Coding after the results are available, when you have a more certain diagnosis, is preferable. Otherwise, consider coding the signs or symptoms that prompted the study. Alternatively, depending on local coverage determinations, some Medicare contractors might accept an unspecified code such as 496 (chronic airway obstruction, not elsewhere classified), 780.50 (unspecified sleep disturbance), 780.53 (hypersomnia with sleep apnea, unspecified), or 780.57 (unspecified sleep apnea). Private insurers may not follow these guidelines.

Annual wellness visits providers

Q What specialties may perform the annual wellness visit?

A The Centers for Medicare & Medicaid Services does not restrict this service to physicians in certain specialties. Nonphysicians may also perform this visit. For more information see page 4 of the following document: <http://go.cms.gov/ZPTxbR>. **FPM**

Editor's note: Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

Send comments to fpmedit@aafp.org.