

CODING & DOCUMENTATION

Cindy Hughes, CPC

Vaccinations and Medicare annual wellness visits

Q Tdap and zoster vaccinations are indicated for Medicare patients but are not required elements of the Medicare annual wellness visit. How do you suggest handling these?

A These vaccines are covered only under Medicare Part D prescription plans. You can either provide patients with a prescription to receive these vaccinations from a pharmacy that participates with their Part D plan or provide the vaccinations as an out-of-pocket cost to patients and provide them with a claim form to submit to their Part D plan for any benefits payable for out-of-network services. For more information, see <http://bit.ly/piGU3S>.

Vision exams for Medicare patients

Q If a Medicare patient has had a recent eye exam by an optometrist or ophthalmologist, must I still provide one to meet the requirements of the annual wellness visit?

A An eye exam is not required for the annual wellness visit but is required for the Welcome to Medicare physical. In this patient's case, it should be sufficient to note that the exam was not conducted due to a recent exam by another provider. If available, document the results of that exam.

ICD-10 transition

Q Will it be possible to crosswalk ICD-9 codes to ICD-10 codes to ease the transition?

A There is not a one-to-one correlation between the two code sets, so crosswalking the codes isn't practical. The ICD-10 code set is more than five times larger than ICD-9 and requires much greater specificity in code

selection. For more information about ICD-10, which must be implemented by Oct. 1, 2013, see <http://www.cms.gov/icd10>. AAFP resources are available at <http://bit.ly/pQCHDw>.

Medicare provider status and billing for annual wellness visits

Q As a non-participating Medicare provider, how should I bill for the preventive services with waived deductibles? Can I collect payment at the time of service, or am I obligated to "accept assignment" as I do for flu and pneumonia vaccinations?

A You are not obligated to accept assignment on the annual wellness visit. To collect from the patient at the time of service, check the Medicare fee schedule for your area to determine the limiting charge. You may collect a fee up to the limiting charge at the time of service.

Keloid injection

Q What code should I report for an injection into a keloid?

A Code 11900 should be used to report intralesional injection (other than for local anesthesia or chemotherapy) of up to 7 lesions. Be sure to report only one unit for up to 7 lesions, even if some lesions require more than one injection.

Editor's note: While this department attempts to provide accurate information and useful advice, payers may not accept the coding and documentation recommended. You should refer to current coding manuals and the *Documentation Guidelines for Evaluation and Management Services* for the most detailed and up-to-date information. **FPM**

About the Author

Cindy Hughes is the AAFP's coding and compliance specialist and is a contributing editor to *FPM*. Author disclosure: no relevant financial affiliations disclosed. These answers were reviewed by the *FPM* Coding & Documentation Review Panel, which includes Robert H. Bösl, MD, FAAFP; 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 Sallings, CPC; and Susan Welsh, CPC, MHA.

DO YOU HAVE A CODING OR DOCUMENTATION QUESTION?

Send it to *FPM* by e-mail, fpmedit@aafp.org; by mail, *Family Practice Management*, 11400 Tomahawk Creek Parkway, Leawood, KS 66211-2680; or by fax, 913-906-6010. Include your address, daytime phone number and fax number. We cannot respond to all questions we receive, but we will publish answers to selected questions.