

CODING & DOCUMENTATION

Cindy Hughes, CPC

Immunization visit for new patient

Q Can we bill 99202 for a visit with a new patient who presents for immunizations only? Our physician obtained a full history, medication and allergy lists, and a minimal review of systems.

A If the key elements of an evaluation and management (E/M) service were performed and documented (i.e., history, exam, and medical decision making) and the service was medically necessary, it would be appropriate to report a new patient office visit code in addition to codes for the immunization and its administration. The level of E/M service depends on the extent of the history, exam, and medical decision making. A level-2 new patient visit requires an expanded problem-focused history and exam and straightforward decision making. You should append modifier 25 to the E/M code to show it was significant and separately identifiable from the immunization.

ICD-9 codes for obesity

Q What diagnosis codes should we submit for the new Medicare benefit for intensive obesity counseling?

A With HCPCS code G0447, “face-to-face behavioral counseling for obesity, 15 minutes,” you must report ICD-9 codes that indicate a body mass index of 30 or greater. These are V85.30-V85.39 and V85.41-V85.45.

EHR overstating exam level?

Q My electronic health record (EHR) system automatically suggests a level of service for E/M services, but it seems to overstate the level of exam. For instance, when I enter abdominal pain, it counts this as an element for both the abdominal

body area and the gastrointestinal organ system. Is this incorrect?

A The EHR is incorrectly duplicating the exam element. You may not count the same exam element toward both a body area and an organ system. You should also keep in mind that the level of exam may be determined by the number of body areas or organ systems examined, but not a combination of the two, according to the 1995 *Documentation Guidelines for Evaluation and Management Services*.

While the EHR may suggest a code, it does not assume liability for errors. It is best to use your judgment and, when in doubt, consult the documentation guidelines. Relying solely on the EHR can result in over-coding because the scoring system built into the EHR does not have enough artificial intelligence to properly consider medical necessity or the nature of the presenting problem.

When a Medicare annual wellness visit follows a Welcome to Medicare physical

Q After providing an Initial Preventive Physical Exam (IPPE), also known as the “Welcome to Medicare physical” (G0402), to a patient in his or her first year of Medicare eligibility, can I provide an initial annual wellness visit (G0438), or should I provide a subsequent annual wellness visit (G0439) instead? How soon following the IPPE will Medicare pay for the wellness visit?

A The initial annual wellness visit must take place before a subsequent annual wellness visit in order to establish the required components that will be updated at subsequent visits. The initial annual wellness visit must occur no earlier than the same month of the year following the IPPE.

Editor’s note: While this department attempts to provide accurate information, some payers may not agree with the advice given. **FPM**

About the Author

Cindy Hughes is a coding and compliance consultant with Medical Revenue Solutions, based in Oak Grove, Mo., and a contributing editor to *Family Practice Management*. 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?

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