

CODING & DOCUMENTATION

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Addressing a new problem during an incident-to visit

Q A nurse practitioner in our practice provided a follow-up visit for hypertension. The encounter met all the requirements for billing incident to the physician, except that the patient also presented with a new complaint, for which an antibiotic was prescribed. How should this be billed?

A Because a new problem was addressed, the service was not provided in continuation of the physician's plan of care, as the incident-to provisions require. Therefore, the nurse practitioner should bill for the services provided under his or her own name and provider identification number.

Getting paid for wart removal

Q Our practice is receiving claims denials from Medicare for wart removal. We are using diagnosis code 078.10, but the Medicare administrative contractor says removal is not covered for this diagnosis. What is the appropriate code?

A You should review your Medicare administrative contractor's local coverage determination for removal of benign skin lesions. Typically, payment requires using a secondary diagnosis code to substantiate that there is a complication such as inflammation or pain that necessitates removal or destruction of benign skin lesions, including warts.

Transitional care vs. chronic care management

Q Is it acceptable to submit a transitional care management code once per 30 days if we are continuing transitional care?

A Transitional care management is for true transitional care, not ongoing care management. Transitional care does not extend beyond the 29-day period

About the Author

Cindy Hughes is an independent consulting editor. Author disclosure: no relevant financial affiliations disclosed. These answers were reviewed by members of the *FPM* Coding & Documentation Review Panel, including Kenneth D. Beckman, MD, MBA, CPE, CPC; Robert H. Bösl, MD, FAAFP; Marie Felger, CPC, CCS-P; Thomas A. Felger, MD, DABFP, CMCM; Emily Hill, PA-C; Joy Newby, LPN, CPC; and Susan Welsh, CPC, MHA.

following the day of discharge. For continued care management services, physicians should consider whether the services meet the reporting requirements for the new chronic care management code, 99490 (learn more about this code in the article on page 7 in this issue). Alternatively, care plan oversight codes might be appropriate depending on the setting: home health (99374-99375); nursing facility (99379-99380); hospice (99377-99378); or home, assisted living facility, or other domiciliary (99339-99340).

Billing Medicare for telehealth services

Q How should I bill Medicare for telehealth services?

A This service must be provided using an interactive audio and video communications system to a patient in certain health care facilities (including physician offices) in a rural Health Professional Shortage Area, in a county outside of a Metropolitan Statistical Area, or at an entity participating in a federal telemedicine demonstration project. The appropriate CPT or HCPCS code should be reported with modifier GT appended to indicate the telehealth service was provided via interactive audio and video telecommunications system (e.g., 99203 GT). (Modifier GQ should be appended for services provided in the Hawaii or Alaska federal telemedicine demonstrations via asynchronous technology.) Download a list of covered telehealth services from <http://go.cms.gov/1wADvSl>. Note that inpatient and emergency department consultations are covered services under the telehealth benefits but must be reported with HCPCS codes G0425-G0427 and G0406-G0408 rather than CPT consultation codes.

Physicians should review Chapter 12, Section 190 of the Medicare Claims Processing Manual and Chapter 15, Section 270 of the Medicare Benefit Policy Manual for more information. **FPM**

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

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