

CODING & DOCUMENTATION

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Flu shot timing

Q Does Medicare cover influenza immunizations as soon as new vaccines are available, or are they payable only after a certain date?

A Physicians may provide immunizations as soon as new seasonal vaccines are received in order to avoid missed opportunities to immunize patients, and Medicare provides coverage. Medicare covers influenza immunization once per influenza season. A second immunization may be covered as well if it is medically necessary. The Centers for Medicare & Medicaid Services (CMS) issues seasonal vaccine payment allowances that are effective Aug. 1 (<http://go.cms.gov/2qYQBKH>). Charges for vaccines provided prior to Aug. 1 may be paid at the rates of the prior influenza season. Be sure to also check your Medicare administrative contractor's instructions regarding billing and payment for new influenza vaccines.

Documenting subsequent nursing facility visits

Q What documentation is required to support billing for a subsequent nursing facility visit (CPT 99307–99310)?

A According to CPT, documentation must include two of the three key components or a statement that more than 50 percent of the unit/floor time devoted to an individual patient was spent in counseling and/or coordination of care. For Medicare patients, documentation must also include evidence of a face-to-face encounter and medical necessity for the level of service rendered. CMS also notes that a large number of patient visits by a single physician on the same date may raise suspicion of “gang visits” and may require documentation to substantiate that visits were either medically necessary or federally mandated. As with all services, the physician or qualified health care professional must authenticate the record with a written or electronic signature including credentials and date.

About the Author

Cindy Hughes is an independent consulting editor. Author disclosure: no relevant financial affiliations disclosed. Reviewed by the FPM Coding & Documentation Review Panel: Kenneth Beckman, MD, MBA, CPE; 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.

Billing for intravenous hydration

Q If a patient is provided intravenous (IV) hydration and an antiemetic by IV push during the same office visit, should both services be reported?

A If the IV hydration (CPT 96360–96361) is concurrent with the IV push administration of an antiemetic (96374–96375), the hydration should not be separately reported. However, if each substance is separately administered, each administration may be separately reported with one designated as the initial service. Physicians should report the service that was the primary reason for the encounter as the initial service, regardless of the actual order of administration. For example, if the key reason for the service was treatment of dehydration, the initial service would be hydration. This would be reported with initial hydration code 96360 for the initial 31 to 60 minutes, followed by code 96361 for each additional 31-minute to 60-minute period. The IV push of the antiemetic would be a subsequent service reported with code 96375 to identify an IV push of a new drug when provided as a secondary service after a different initial service is administered through the same IV access. Additionally, a significant, separately identifiable evaluation and management (E/M) service may be reported with modifier 25 appended to the E/M code.

ICD-10 code for drug abuse in remission

Q Which ICD-10 code should I report for a patient with drug abuse in remission?

A Report code Z87.898, “Personal history of other specified conditions.” ICD-10 does not include specific codes for drug abuse in remission. However, when drug dependence in remission is diagnosed, report a code for the type of drug dependence in remission (e.g., F11.21, “Opioid dependence, in remission”). New codes for drug abuse remission will be added Oct. 1, 2017. **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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