Coding & Documentation

CME

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SAME-DAY RETURN VISIT

Q If a physician sees a patient and instructs him or her to return later that day for a blood pressure check, should our practice bill CPT code 99211 with modifier 25, "Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service," in addition to the code for the first encounter?

A No. You should charge one E/M code for the combined services. Payers typically follow guidance from the Centers for Medicare & Medicaid Services that says two separate office E/M codes may be reported on the same date only when the patient presents for two unrelated problems.

MODIFIER FOR INCIDENT-TO SERVICES

Q Does Medicare require using a modifier to show that an advanced practice provider such as a nurse practitioner or physician assistant provided an office E/M service incident-to a physician's services and billed under the physician's provider identification number?

A No. But some health plans require modifier SA, "nurse practitioner rendering service in collaboration with a physician," for services rendered incident-to or as a shared visit (e.g., the physician and advanced practice professional each provide significant portions of an E/M service). Though HCPCS specifies "nurse practitioner" in the descriptor, modifier SA may also be used when billing for services provided by physician assistants, clinical nurse specialists, or other advanced practice professionals specified in a payer's policy.

INPATIENT CARE BILLING BY TEACHING PHYSICIAN

Q If a resident does an inpatient history and physical examination (H&P) and discusses it over the phone with an attending physician on one calendar day (e.g., 10 p.m. Thursday), and the attending doesn't round on that patient until the next calendar day (e.g., 10 a.m. Friday), can the attending use the resident's documented H&P to support billing for initial hospital care? Or must the resident see the patient again with the physician present and redocument the H&P?

A The teaching physician may reference the resident's note but must also document that he or she personally saw and participated in management of the patient. If after seeing the patient the teaching physician agrees with the resident's documentation and the patient's condition has not changed, the teaching physician may reference that documentation in lieu of redocumenting. Any changes in the patient's condition and clinical course must be documented by the teaching physician. The teaching physician's date of service is the date he or she saw the patient.

The Medicare Claims Processing Manual specifically addresses what documentation is needed when a resident performs initial hospital care late at night and the teaching physician does not see the patient until later, including the next calendar day (see Chapter 12, §100.1.1; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html).

BIOPSY OF THE OUTER EAR

Q I performed a biopsy of a lesion on the external ear. Should I report a code from the integumentary section or the auditory system section of CPT?

A Use code 69100, "Biopsy external ear," from the auditory system section. CPT provides this instruction at the end of the prefatory instructions for the biopsy codes in the integumentary section.

MULTIPLE X-RAYS

Q Is it appropriate to report two codes for X-rays when one is taken prior to the removal of a foreign body and the other is taken to confirm that all of the foreign body was removed?

A Yes. If the two X-rays are for the same procedure (e.g., same anatomic locations or views), report modifier 76, "Repeat procedure or service by same physician or other qualified health care professional," with the code for the second X-ray. If the second X-ray is a different procedure (e.g., fewer views), you should instead report modifier 59, "Distinct procedural service." In either case, be ready to provide documentation if the payer requests it, including the images and a report of findings that describes indications for and any limitation of the exam, details of images reviewed (e.g., lateral or posterior), any comparisons, clinical questions answered, and impressions. FPM

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EDITOR'S NOTE

Reviewed by the *FPM* Coding & Documentation Review Panel. Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

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