

FAQ

If you have any questions regarding the following, please direct all your questions to: efaq@wismed.org.

Medicare / Medicaid

- Medicare does not recognize the New CPT codes for anti-coagulation management in 2007. If a nurse is performing a Prothrombin time test, is it appropriate to also bill an E&M using 99211 to Medicare?
- Our practice is considering contracting with a pharmacist (Pharm D) to assist in our anti-coagulation clinic and to assist in medication management plans for chronic pain management. Can Pharm Ds bill under the "incident-to" guidelines?

CPT Coding

- How does one report the performance of both a screening mammogram on the right breast and a diagnostic on the left breast at the same encounter?
- If a patient has a lab draw through a Venous Access Device and irrigation/flush, can the irrigation be billed separately?
- Do I report CPT codes 99455-99456 when performing treatment of a work-related injury/problem?
- Our OB/GYN physicians want to know what constitutes a "simple" or "extensive" procedure for codes 56501, destruction of lesion(s), vulva; simple; and 56515, destruction of lesion(s), vulva; extensive. What is the guideline for this?
- When is it appropriate to report CPT code 99173, screening test of visual acuity, quantitative, bilateral?
- How would I code the following situation? AP, Lateral and Sunrise Views of the Left Knee and an Upright PA of both knees was obtained today. Comparison Views: There were no comparison views. Findings: The x-rays show moderate osteoarthritis of the left knee, primarily lateral compartment, with loss of joint space on weight-bearing view. Chondrocalcinosis is present. The right knee components appear stable. Impression: Left knee moderate osteoarthritis. Left knee chondrocalcinosis. Stable right total knee arthroplasty.
- Is it appropriate to bill CPT codes 17106 through 17108 when using lasers to treat diagnosis code 448.1 (Telangiectasia)?
- When is it appropriate to report CPT 69210, removal of impacted cerumen (separate procedure), for one or both ears?
- Is it truly the intention of CPT to require a separate, signed, written and retrievable report for EKG interpretation? If so, does this requirement apply to all codes that have interpretation and report in the verbiage (for example: an X-ray performed in the office)?

ICD-9 Coding

- Is there a cut off time period when using "history of" ICD-9-CM codes?
- What diagnosis should be used for a patient who is finished with treatment of their breast cancer, but remains on Tamoxifen?

E&M

- What do I do if my patient is a poor historian or a history cannot be obtained?
- Can negative responses be included in the history of present illness (HPI) elements?
- Who can perform and document the chief complaint?
- Who must obtain and document the review of systems (ROS), past medical, family and social history (PFSH)?
- Who can perform and document the HPI?
- What type of verbiage should be avoided when documenting the ROS and/or PFSH?
- If the physician dictates, "the patient presents with a headache that he has had for two days", can we count both the Chief Complaint and the HPI element of location using this one statement?
- Where does the statement "Patient is in no acute distress" fall within the examination elements?
- Can one utilize the status of 3 chronic conditions when using the 95' DG?
- Can ancillary staff perform and document the vital signs?
- When utilizing the 95 documentation guidelines can you combine body areas with organ systems?
- Is a provider able to "cut and paste" previously dictated examinations when following a patient for a chronic problem once it has been diagnosed?
- Can presenting problems such as sinusitis be considered a "new problem" if it is a new onset, or is it always an established problem once it has been diagnosed?
- Under MDM in reference to the amount and/or complexity of data reviewed would a physician be able to "count" 3 points if he/she ordered a specific radiology test and also performed direct visualization of image, tracing, specimen, etc?

Does a verbal recommendation for further work-up "count" as an ordered test if the patient declines during the encounter? Additionally, if the patient leaves the office visit with the order and fails to follow-through, would this then count toward further work up?

WMGMA Medicare/Medicaid Workgroup

These FAQs can be found on the [WMGMA Web site](#).

Medicare/Medicaid

Medicare does not recognize the New CPT codes for anti-coagulation management in 2007. If a nurse is performing a Prothrombin time test, is it appropriate to also bill an E&M using 99211 to Medicare?

You should not routinely bill a Prothrombin blood draw (85610) with an Evaluation and Management service. WPS Medicare Part B published an article in the June 2006 *Communique* describing situations when this would be acceptable. Keep in mind that documentation on the INR flow sheet alone is not sufficient for billing 99211. There must be a new symptom or a reason clearly identified and documented to support billing a 99211. In addition, Medicare "incident-to" guidelines must be met. This would include the direct supervision component, requiring the physician to be available in the office suite.

Click [here](#) to learn more.

Our practice is considering contracting with a pharmacist (Pharm D) to assist in our anti-coagulation clinic and to assist in medication management plans for chronic pain management. Can Pharm Ds bill under the "incident-to" guidelines?

Pharm Ds may provide services under the Medicare "incident-to" guidelines when all appropriate incident-to criteria is met. Pharmacists are not a recognized provider type by CMS and therefore will fall into the "non-physician" definition of "incident-to," limiting them to reporting these services as a low-level clinic visit with CPT 99211.

[back to top](#)

CPT Coding

How does one report the performance of both a screening mammogram on the right breast and a diagnostic on the left breast at the same encounter?

If a screening mammography is performed on the right breast and a diagnostic mammogram on the left breast, then it is appropriate to report 76092, 52, *Screening mammography, bilateral (two view film study of each breast)* and 76090, *Mammography; unilateral*. Please note that 76092 is inherently bilateral, therefore, modifier 52, *Reduced Services* is appended to identify performance of the procedure on only one breast. Third party payers may require appending of modifiers RT & LT in this situation.

If a patient has a lab draw through a Venous Access Device and irrigation/flush, can the irrigation be billed separately?

No. The irrigation/flush cannot be billed if there is any other service performed and billed during the same encounter.

Do I report CPT codes 99455-99456 when performing treatment of a work-related injury/problem?

CPT codes 99455-99456, Work Related or Medical Disability Evaluation Services, only represent the evaluation necessary to complete forms. When the sole purpose of the encounter is to provide active management and/or treatment of the work-related injury/problem, report the appropriate E/M service code.

Our OB/GYN physicians want to know what constitutes a "simple" or "extensive" procedure for codes 56501, destruction of lesion(s), vulva; simple; and 56515, destruction of lesion(s), vulva; extensive. What is the guideline for this?

Simple is a single, simple destruction. Extensive is multiple or complicated destruction. The determination of whether the destruction is simple versus extensive is based on physician discretion. The physician should state within his or her documentation whether or not the destruction of such a lesion was felt to be simple or extensive.

When is it appropriate to report CPT code 99173, screening test of visual acuity, quantitative, bilateral?

CPT code 99173 is only reported with well-child care or sick-child visits not directly related to eye complaints or injuries.

How would I code the following situation? AP, Lateral and Sunrise Views of the Left Knee and an Upright PA of both knees was

obtained today. Comparison Views: There were no comparison views. Findings: The x-rays show moderate osteoarthritis of the left knee, primarily lateral compartment, with loss of joint space on weight-bearing view. Chondrocalcinosis is present. The right knee components appear stable. Impression: Left knee moderate osteoarthritis. Left knee chondrocalcinosis. Stable right total knee arthroplasty.

The first CPT code is 73565 no modifier; the second, based upon the documentation above, is 73562 LT-59, as this is bundled into the first code and has to be overridden with the 59.

Is it appropriate to bill CPT codes 17106 through 17108 when using lasers to treat diagnosis code 448.1 (Telangiectasia)?

No, spider veins are not vascular proliferative lesions. Generally, the treatment of spider veins, etc., is cosmetic, and therefore is not a covered service by Medicare or many other carriers. If the treatment is medically necessary, you could use CPT codes 17110-17111.

When is it appropriate to report CPT 69210, removal of impacted cerumen (separate procedure), for one or both ears?

CPT Guidelines state the reporting of 69210 involves direct visualization, in which the physician is removing impacted cerumen using suction, a cerumen spoon, or delicate forceps. If no infection is present, the ear canal may also be irrigated. If the use of an operating microscope is necessary you may also bill for the add-on code 69990, "Microsurgical techniques requiring use of an operating microscope". Medicare will not pay additionally for the use of the operating microscope with code CPT 69210 per *Claims Processing Manual 100-04*, Chapter 12, Section 20.4.5.

A major element in determining if you should report 69210 is understanding the definition of impacted cerumen. The July 2005 CPT Assistant states, "*By definition of the American Academy of Otolaryngology-Head and Neck Surgery, if any one or more of the following are present, cerumen should be considered 'impacted' clinically:*

- . *Visual considerations: Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.*
- . *Qualitative considerations: Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.*
- . *Inflammatory considerations: Associated with foul odor, infection or dermatitis.*
- . *Quantitative considerations: Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills."*

Removing wax that is not impacted does not warrant the reporting of CPT code 69210. If it is necessary to remove wax that is not impacted, this service would be captured in the reporting of an Evaluation and Management Service, regardless of how it is removed. For Medicare payment purposes, if the physician's services for medically necessary cerumen removal occur on the same day as an audiology exam, use HCPCS code G0268. Otherwise, routine cerumen removal associated with audiologic testing is considered a bundled component of the testing and is not separately payable. Because it is considered a surgical procedure, Medicare will not pay for cerumen removal when billed by an audiologist.

Is it truly the intention of CPT to require a separate, signed, written and retrievable report for EKG interpretation? If so, does this requirement apply to all codes that have interpretation and report in the verbiage (for example: an X-ray performed in the office)?

In the 2007 CPT codebook, instructions were added to each CPT section with guidelines to clarify (1) the meaning and relationship of a report to other services provided and (2) the intent of the inclusion of the term report in many descriptors and guidelines.

In the 2008 CPT codebook, these instructions have been removed from the individual sections and a revised definition has been placed in the "Instructions for Use of the CPT Codebook", found in the codebook's "Introduction," because this definition is relevant to all instances of these terms in the CPT codebook. The definition has been expanded to clarify the relationship of results and interpretation of the results to procedures that have a technical component requiring interpretation.

Therefore, from a CPT coding perspective, the following definition of results, testing, interpretation and report apply wherever these terms appear in the CPT codebook, according to the instructions in the codebook: "Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of test results. Certain procedures or services described in the CPT codebook involve a technical component (eg, tests), which produce results (eg, data, images, slides). For clinical use, some of these results require interpretation. Some CPT descriptors specifically require interpretation and reporting to report that code."

[back to top](#)

ICD-9 Coding

Is there a cut off time period when using "history of" ICD-9-CM codes?

The code classification for "history of" does not define a time limit. History codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment. Please note that physicians sometimes include in the diagnostic statement historical information or status post procedure from a previous admission. These have no bearing on the current stay, and such conditions are not reported.

What diagnosis should be used for a patient who is finished with treatment of their breast cancer, but remains on Tamoxifen?

Tamoxifen therapy can either be curative or palliative. Here are three examples of when and how Tamoxifen therapy should be coded.

Example #1

The patient had a breast malignancy and is status post mastectomy. She completed her course of chemotherapy and radiation six months ago and is now being prescribed Tamoxifen as adjuvant treatment. Tamoxifen therapy was not started until after the chemotherapy course was finished.

Assign:

174.9, Malignant neoplasm of female breast, Breast (female), unspecified

V58.69, Long-term (use) current of other medications

Explanation:

Tamoxifen is being prescribed as adjuvant or additional therapy to prevent a recurrence, following treatment of primary breast cancer. Adjuvant or additional therapy is still considered part of the cancer treatment. Since the patient is still receiving active treatment for the breast malignancy, code 174.9 is assigned instead of code V10.3.

Example #2

The patient has a history of breast cancer, status post mastectomy with completed course of chemotherapy and radiation five years ago. The physician clearly stated that the patient is cancer-free. However, the patient is now being prescribed Tamoxifen in an effort to prevent a recurrence of the breast cancer.

Assign:

V10.3, Personal history of malignant neoplasm, Breast

V58.69, Long term (use) current of other medications

Explanation:

The physician has declared this patient cancer-free and she is receiving Tamoxifen as preventive therapy several years following completed treatment.

Example #3

After discussing various treatment options with her physician, a well asymptomatic woman with a strong family history of breast cancer is prescribed Tamoxifen as preventive therapy for breast cancer.

Assign:

V65.49, Other specified counseling

V16.3, Family history of malignant neoplasm, breast

Explanation:

This advice is consistent with that previously published in Coding Clinic, Second Quarter 2000, page 8.

[back to top](#)

E&M

What do I do if my patient is a poor historian or a history cannot be obtained?

First, you must always document the facts surrounding the reason you were unable to obtain the history. Keep in mind that in this scenario, you may be able to obtain the history from other providers, family or friends. If no history is obtainable you must choose your level of service based on the following:

- If the service requires two of three key elements per CPT requirements (e.g. established or subsequent hospital patient), report the level of service based on the examination and MDM elements.
- If the service provided requires three of three key elements to be met or exceeded (e.g. new patient, consultation, initial hospital care) report the level of service based on the payer.
- WPS Medicare Part B: Report Unlisted Code 99499
- When choosing a fee for an NOC code, the physician should bill the amount he or she believes reflects the quantity of work performed in the service.
- The AMA does not have documentation requirements for choosing levels of service. The reply we received from them on this question was to adhere to the CMS 95' or 97' Documentation Guidelines.

*Two other considerations:

- Is time the controlling factor in this visit and can this encounter be billed based on time per the documentation?

- Does this encounter meet the requirements of the Emergency Room caveat associated with CPT 99285?

The definition of CPT 99285 includes the concept that the History, Physical Exam, and Medical Decision Making requirements must be met "within the constraints imposed by the urgency of the patient's clinical condition and/or mental status." The clinical circumstances, which prohibit the physician from obtaining a history or performing an exam, must still be documented.

Can negative responses be included in the history of present illness (HPI) elements?

Per WPS Medicare Part B, yes both pertinent positives and negatives may be included in the HPI. However, as a general rule, the HPI consists of subjective complaints that come voluntarily from the patient. Pertinent negative responses that are the result of questions posed to the patient by the physician usually fall under the Review of Systems.

Who can perform and document the chief complaint?

Per the Documentation Guidelines, the chief complaint is required for all levels of history and must be clearly reflected in the medical record. Ancillary staff cannot perform and document a chief complaint (CC). The CC is part of the HPI, which must be performed by the physician. br/>

Who must obtain and document the review of systems (ROS), past medical, family and social history (PFSH)?

The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

- A ROS and/or a PFSH obtained during an earlier encounter do not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record.
- The review and update may be documented by:
 - describing any new ROS and/or PFSH information or noting there has been no change in the information; and
 - noting the date and location of the earlier ROS and/or PFSH.

Who can perform and document the HPI?

The physician or NPP must personally perform and document the HPI.

What type of verbiage should be avoided when documenting the ROS and/or PFSH?

Avoid common documentation pitfalls:

- "Non-contributory" is ambiguous and some providers take it to mean the system was not relevant, therefore was not reviewed, while others take it to mean that the system was reviewed, but had no pertinent findings to be reported.
- When using a pertinent negative be sure to describe the same as if abnormal was the verbiage used.

If the physician dictates, "the patient presents with a headache that he has had for two days", can we count both the Chief Complaint and the HPI element of location using this one statement?

Per WPS Medicare Part B, "If the chief complaint is headache the location of the HPI would be the head. (The two are very similar.) The remainder of the HPI elements would clarify the concern of the headache. The Chief Complaint and the HPI support each other, however, the same element cannot be assigned to both (HPI and ROS)."

Where does the statement "Patient is in no acute distress" fall within the examination elements?

Per WPS Medicare Part B, this statement typically falls under the constitutional element.

Can one utilize the status of 3 chronic conditions when using the 95' DG?

Per CMS, yes. Although this information is physically present in the 97' DG it is also implied in the 95'DG.

Can ancillary staff perform and document the vital signs?

Simple blood pressure readings, pulse, temperature and weight checks are the type of typical activities performed by ancillary staff during an encounter. The physician can use this information and would not need to physically repeat them, as this would be an unnecessary burden. It must however, be clear in the documentation that the provider has noted this information and did not personally obtain it.

When utilizing the 95 documentation guidelines can you combine body areas with organ systems?

It is appropriate to combine body areas and organ systems for all level of service except the comprehensive multi-system examination. The comprehensive multisystem examination must consist of 8 organ systems. Any body areas used must be above and beyond the 8 organ systems.

Is a provider able to "cut and paste" previously dictated examinations when following a patient for a chronic problem once it has been diagnosed?

No, per the DG, the only elements that may be referenced from previous notes are the ROS and PFSH. All other elements must be performed and documented at each encounter. The exam portion of the encounter is the physical pertinent findings for the current visit related to the chief complaint.

Can presenting problems such as sinusitis be considered a "new problem" if it is a new onset, or is it always an established problem once it has been diagnosed?

New episodes of "acute flare-up" would be considered a new problem to the physician. However, if the physician were following the patient for chronic sinusitis that does not involve an acute flare-up, it would be considered an established problem.

Under MDM in reference to the amount and/or complexity of data reviewed would a physician be able to "count" 3 points if he/she ordered a specific radiology test and also performed direct visualization of image, tracing, specimen, etc?

WPS Medicare Part B "counts" no official "points" or "bullets" in the determination of Medical Decision Making (MDM). However, in such a case as the one described, both the ordering of the test and the direct visualization of the image, tracing or specimen (etc.) would be taken into consideration in the determination of the amount and/or complexity of the data reviewed

Does a verbal recommendation for further work-up "count" as an ordered test if the patient declines during the encounter? Additionally, if the patient leaves the office visit with the order and fails to follow-through, would this then count toward further work up?

YES, both are evidence of the provider's medical decision making, whether or not the patient follows through.

[back to top](#)

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