CODING Q&A

Readers' Coding Inquiries

■ DAVID STERN, MD, CPC

Q. How would you define the difference between an expanded problem-focused exam and the detailed exam in the 1995 evaluation and management coding guidelines?

– Question submitted by Eddie Stahl, Medical Staff Director, Tennessee Urgent Care Associates

A. For both the expanded problem-focused exam (EPF) and the detailed exam, the provider must document between two and seven body systems. The difference is that *the EPF exam* requires a **"**limited**"** exam of a body area, but the *detailed exam* requires an "extended" exam of a body area.

The difference between the limited and extended exams has never been clearly spelled out by the Centers for Medicare & Medicaid Services (CMS), so it has been left to the coder or auditor to determine whether the exam is "limited" or "extended."

As with beauty, the difference is simply in the eye of the beholder.

Of course, this ambiguity has left many coders frustrated with the 1995 guidelines. That is the main reason that CMS came up with the 1997 guidelines. But the 1997 guidelines were too rigid for realistic application to real-world clinical encounters, so CMS has simply allowed providers to use whichever set of guidelines they feel most comfortable using.

Q. We do not receive adequate reimbursement for B-12 injections. Can we charge out a 99211 along with the administration charge and B-12 charge?

– Question submitted by Tammy Higgins, Physicians Care, Chattanooga, TN

A. To use 99211 properly, the chart will need to demonstrate clearly that the nurse did an evaluation and management of the patient's condition. I have previously written fairly extensively on the criteria for using 99211 (see Coding Q&A, *JUCM*, April 2007).

If you are not being reimbursed (i.e., are getting payment denials) for many of the B-12 injections, you may need to look at the ICD-9 that you are using with the injection code. Many payors (including Medicare) limit reimbursement to ICD-9 codes for specific conditions related to B-12 deficiency, such as pernicious anemia and dementias secondary to vitamin B-12 deficiency.

Q. We bill for four clinics that are licensed as "outpatient clinics." We are confused on the place-of-service code because place-of-service 22 states the facility is part of the hospital, but the urgent care seems more appropriate. However, we were told it was *not* appropriate because it must be provider-based and the doctor-owned facility doesn't bill separately for the facility charge. We only bill the professional charge for our doctors.

– Question submitted by Tammy A. Lovely, CMRS, Director of Coding, Apollo Information Services, Inc.

A. No matter what your location (hospital, freestanding, in multispecialty clinic, etc.) or billing structure (facility only, provider only, combination) every payor is likely to see the place-of-service issue differently. There is no hard-and-fast rule for any given payor.

You may minimize denials by using the place of service - 22 (Outpatient Hospital), but it is always best to check with each individual payor. Of course, most of us hate that "check with your payor" phrase because so often the payor representative does not know the answer—or, even worse, gives us the wrong answer.

Q. We have a radiologist read every x-ray study that we do. How should we code for this?

– Question submitted by Giridhar C. Kamath, DO, Surya Immediate Medical Care, Latham, NY

A. Physicians may use one of three coding methods in this situation. Your radiologists may have a strong preference for the one or the other.

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1. Bill technical component only (modifier -TC); then the radiologist will bill the professional component (modifier -26).

2. Bill global code. The radiologist would be an employee of your clinic who would sign an independent contractor agreement and work under the guidelines provided by the IRS for independent contractors.

3. Bill global code. If the radiologist does an over-read only when you are asking a radiologist a specific question, then you may want to bill the global for the x-ray and then the radiologist will bill a second read with modifier -77 -26 (repeat procedure by another physician).

Although this is a legitimate coding method that has been specifically authorized by several Medicare carriers, the radiologists may not want to use this coding method, as some plans may not pay for the second opinion reading of the x-ray.

Whatever method you choose, you may want to specifically get an opinion from a lawyer with expertise in this field and save the written opinion in your compliance files.

Q. In reviewing one payor's EOBs, I noted that a patient was seen and had an influenza A/B screen. The payor only reimbursed $7.04 for the test, which does not even cover the purchase price of the test.

It seems crazy that we would not even get back 50% of our outlay. Could we code for two tests or units, as we are testing for both influenza A and influenza B?

The test manufacturer's website seems to indicate that is acceptable, but does mention that some local payers may have different policies.

All the flu tests that we do are for A and B. If we were able to charge for two tests, at least we would come close to covering our cost for the product, which is close to $16 per test kit.

– Question submitted by John Opyoke, Trinity Urgent Care, Trinity, FL

A. Great point! Coding influenza tests depends on the type of test being done. If the test gives a generic "positive flu" result, then use code 87804 only once. If the test gives one result for influenza A and a second result for influenza B (example: positive for flu A and negative for flu B), then use code 87804 twice.

You would want to append modifier -59 (repeat procedure, same physician) to the second code. As always, local payors may have specific policies regarding coding and reimbursement for influenza test, so it is a good idea to check with them before submitting billing for these tests.

Note: For Medicare, you will want to also add modifier –QW to this and all other CLIA-waved tests. ■

business because they fear rejection.

Consequently, closing verbiage often becomes hesitant, meandering, or even disingenuous. The best way to ask for the business is to *ask for the business* as directly as possible.

"The best rule is to look someone in the eye and say what you think."

Rule #7: Learn from Your Written Edits

If you conscientiously edit your written correspondence (rule #1) you will begin to see patterns such as over-used words or irrelevant tangents. These tendencies tend to crop up in my verbal communiqués.

For example, my first drafts tend to be over-populated by dramatic adjectives ("very," "extremely," "extraordinary") that—no surprise—find their way into my verbal expressions. It is instructive to note any "excess written verbiage" tendencies and strive to minimize these tendencies in conversation.

Rule #8: Silence is Golden

Given most conversations, you would never know it. Many sales professionals consider even a few seconds of silence an unacceptable void that must be filled with a stream-of-consciousness discourse.

To the contrary, one should sit still or steer things back to the prospect with such open-ended queries as "Anything else?" and "Your thoughts?"

Rule #9: Tighten Your Response to Questions

People tend to ramble on when answering questions. Strive to respond to questions with no more than a succinct sentence or two. Here are some hints:

Repeat the question. This gives you time to organize your response and ensure that you understand the question.

Pause between sentences. Give the other party a chance to clarify or accept your answer as sufficient.

Always conclude, "Does this adequately answer your question?"

Rule #10: Straight Talk—Above All

The best rule of all is to look someone in the eye and say exactly what you are thinking. Selling your clinic's occupational medicine services is about creating "win-win" situations in which your clinic's capabilities address the prospect's needs. No hocus pocus—learn a prospect's needs, describe your solution, define and quantify the win-win, and begin service.

The more quickly and precisely you get from point A to Point D, the better off you will be. ■