Frequently asked questions

12/19/2014

1. In reference to the modifier 25 usage, a child comes in for a Well Child Exam and has an additional finding which requires a different medical intervention other than what goes into that exam, there is a fine line here. Can I do a modifier 25 on a bilirubin for a full well child checkup on a 3 day old, who is jaundice? This is the first time the baby has been seen in clinic.

   No, not for a bilirubin as an additional sick on a 3 day old; we will charge for the lab, based on the periodicity schedule, they get the newborn check up and then discharged to five days. If it is outside of the periodicity schedule and there are additional concerns, then, yes. For example, a 7 day old, if they come in and they are still having problems and the levels are high and you do additional things outside the regular schedule. Then, Yes, But you must have separately identifiable things documented.

2. Is it a myth that you cannot bill higher than a 99213? Yes, you can bill higher based on what your documentation warrants.

3. Dental H & P is billed as a well check? Yes, dental clearance is coded as a well-check.

4. If a patient comes in for clearance, you can code that this is something outside the periodicity.

Periodicity schedule is available from Texas Health Steps, under Provider information.

1/16/2015

1. Can we bill for time on time for an established patient? Yes, for an established patient, if in general you are going to spend 45 minutes to get the 99215, and then you are going to sit there another 30-45 minutes discussing whether you are going to refer the child to Texas Children's Hospital, for example, for overnight surgery and you are going to sit and discuss that detail with the patients, just make a brief note reflecting the total amount of time you spent with the patient and also make a brief note indicating the coordinated care with Texas Children's Hospital, than we can build the whole note on time as a 99354.

2. Can you clarify the scribing services situation? If you are scribing, you just say who you are (NPP) and what you are and describe the service you are scribing, then the doctor comes behind and confirms the scribe documentation, with his or her statement (see slide 5) after the scribes.

3. The prenatal counselors council in the MFM department on patients on their own, they bill under Dr. Lockhart because she is in the vicinity and can be called on if the patient has more questions or they need assistance. In this context, can they use the same statement? If they are Medicaid, this is probably fine, but Barbara is going to double check.

4. If a child stays in my clinic for an hour and receives counseling, coordination of care for OT, PT, speech and so forth, can I still bill off of that or is that only direct face to face time? Yes, you should bill this on time and for coordination of care.

5. In the nephrology example on E&M Session 5, how can "elevated blood pressure "and "weight gain" qualify as a level 5? You must look at your **length** of decision making, you started a new medication, you ordered an ultrasound, and you referred the patient to Pedi cardiology.

6. In travel clinic, I spend about 45 minutes talking to them about what they need, but when I try to bill as a level 4, the systems says I can't bill as a level 4; why? If they are BCBS and they are a employee, then we bill to the carrier just fine. IN the case of self-pay, then they will be billed at $85 for one family member or $50 for multiple family members. No matter how much time, the price is the same. Some carriers will pay for the visit and some vaccinations, but not all of them. So those vaccinations have to be billed as a separate encounter.

1/30/2015

1. Is Nasal Cannula and Room Air a conflict? No, but put both together so the coders are sure of what is happening.

2. How do you do the billing for Nasal cannula? The level of the leader affects the code for cannula. There are certain guidelines in place for being critical versus being intensive depending on the level of nasal cannula.

3. Can I copy and paste? Yes, but only if you read and edit what you have copied and pasted.

4. Do you look at the faculty attestation? Yes, we do and it does help, but sometimes the note is a little contradictory because the note has been copied and pasted and not updated, but it can be a big help.

5. The 99460-99462 99463 is a completely normal baby with no problems, if the baby is a LGA or a SGA, do we sneak over and start using the 99221? Usually we do because usually, on the first day if they are LGA, they have a little something going on. If there is not anything going on than we would not. But usually there is, especially on the first day.

6. What about the modifiers? The only one we really use is the modifier 25 and that is for an identifiable service on the same day as the E&M, like circumcision. This is a separate identifiable service in addition to your E&M service. this is automated so, that the proper codes drop automatically.

7. They QA 100% for newborns.

8. If a baby is born and he is in the newborn nursery and his evaluation and write up are complete, as a 99640, but gets sick and goes to ICU? He will go to the critical care codes, but it depends on how it is documented. Can bill for both, but it does depend on how well it is documented.

2/13/2015

1. IF the patient was admitted late on day 1 and seen only by a resident, and on day 2 a faculty member saw they patient, how do you bill for that?

   The faculty has to document their own consultation note if not; they have to see the patient with the resident or the same day as the resident. There is a 24 hour rule, that falls into place for the initial hospitalization and that only applies to their initial H&P. If faculty does see them the next day and sometimes the resident does still follow them, you will get some credit, you will get a subsequent level visit, but you will not get the consult visit credit. To get consultation credit, the faculty has to document their own consultation note, which requires all three key components.

2. What is preferable to use, the time statement or just pick the code? For example, "if I put 99244, it says I have 60 minutes? So, is that 60 minutes exclusively the physician time or is it total time? So, for 99244, if I put a statement that 60 minutes was spent and more than 50% was spent on coordination of care, which one is better?

   If you are stating that more than 50% is spent on coordination of care, which has to be faculty time, and your documentation says you meet a 99244, than that is fine. That is what will be billed. If you documentation meets the level than you don't have to put the time statement.

3. If a patient comes in for chemotherapy on Sunday, but gets admitted, we are doing a lot of work on the phone and making decisions, but we don't usually bill until Monday, is this ok?

   This is not a consultation, this is an initial admission and this is fine, because you can bill an initial H&P with in 24 hours. You use all the documentation, including the resident documentation as the initial care for billing purposes.

3/13/2015

1. Can these codes be used ONLY by mental health professionals, not be pediatricians? Yes, these codes can only be used by mental health professionals. That is correct. General Pediatricians will use the regular E&M Code.

2. Do the behavioral pediatric folks use these codes? No, they do not. They use E&M codes.

3. Can a child see a general pediatrician for a well-child visit and a psychologist for a mental health visit on the same visit? If they came to see someone for an E & M visit or a sick visit and they wanted to bring you in to evaluate the child then the mental health code would be a 90832, but it cannot be the 90791.

4. Can a child see a general pediatrician for a well-child visit and later that day, a psychologist for a mental health visit on the same visit? Yes, this is coded as normal.