# Answers for questions gathered at PCC's Pediatric Practice Management and Coding Conference in Washington D.C. in April 2008.

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1. What RVU is associated with 99058 (emergency)? Do insurers pay?
   The 99058 CPT code has no RVUs. There are, indeed, many insurers that pay the office emergency code however. Of course, payment will vary from one carrier to another – payments are usually between $20 and $75. When using this code, remember to document the fact that the service was indeed an emergency, as we all know that not all walk-ins are emergencies.

2. Can/should you charge for IM administration of antibiotic?
   Yes, you should bill for an administration of an antibiotic but you cannot use the administration codes for vaccines (90465-90468 and 90471-90474). You will need to use the 90772 code (Therapeutic, prophylactic or diagnostic injection subcutaneous or intramuscular). Many carriers will want to bundle this in with the office visit or, *worse,* bundle the office visit in with the injection. To try to override this bundling edit use a -25 modifier on the visit and 59 on the 90772. Don't forget to bill for the medication (using the J code at the right dosage).

3. Should you use the 90862 for "Med Management" or can you just use the appropriate E&M code for ADHD f/ops?
   The 90862 typically reimburses slightly lower than a 99213 office visit code. If the physician takes a history and does an exam in addition to discussing with the parent(s) the continued use of the medication, then the visit would be, at a minimum, a 99213. However, if there is some lengthy discussion then the visit could even be a 99214 or 99215, depending on the amount of time that is involved. Remember, with this type of visit you should consider using time as a key factor when determining the level of care.

4. Do you have to keep a copy of the consult report in the medical record? Or just chart the fact that you sent the report?
   Yes, you should keep a copy of the consult report in the medical record. One of

the criteria for a consult is a report to the requesting party. This should usually be in the form of the consulting report/letter or the form that was filled out as a request, such as a preoperative clearance for surgery consultation H & P form or the form from the school nurse. Of course, any form of communication with the requesting party should also be in your chart.

5. Why are my 90467 and 90473 never paid (intranasal admin of vaccines when well child checkup rendered)? For example, FluMist when provided during check up.
   First, make sure when billing for the FluMist that you don't use the initial code (90467, 90473) if you have already used the initial injection administration code (90465, 90471) on the same day. If you think about all vaccines given in total, it makes sense. Unless the intranasal vaccine is the first one administered, you need to use the subsequent intranasal. It is not accurate to bill an initial intranasal code if you have already billed an initial injection code. There can only ever be *one* initial administration whether by injection or nasal/oral route.
   Also, if the insurance company follows Medicare's rules, Medicare does not pay for any oral/intranasal vaccine administration codes because they feel they are self-administered and do not need to be administered by anyone in the office.

6. Isn't the "service fee" for not coming with a copay considered part of "administrative cost" that is factored into the E/M fee?
   Not that we're aware of – has anyone seen documentation of this premise? If so, please share!

7. Where can we get the AAP Coding flip chart?
   You can order the flip chart directly from the AAP at this location:
   <https://www.nfaap.org/netFORUM/eweb/DynamicPage.aspx?webcode=aapbks_productdetail&key=8417fbba-fe6d-477d-8399-e7ce78d2e7e8>
   ...or simply go to the AAP's on-line bookstore and search for "flip chart." Note that it is often included for free if you order enough other material from the store, like your annual CPT guide!

8. How do you determine what % 1.25 or 1.5, etc of RBRVS to use to set fees?
   The easiest method, presuming your existing practice management system does not make this automatic, is to use one of PCC's free on-line RVU calculators:
   <http://www.pcc.com/practmgmt/form.php>
   <http://www.pcc.com/practmgmt/byo_rvu.php>

9. If you see a child in the morning for an ear recheck and then the child falls and hits his head in the afternoon...can you bill for two visits? If so, how?
   You have two choices. First, you can bill two visits. You might want to modify the second one with a -76 modifier to indicate that you did two services on the same day for the same patient.
   Or, you can *combine* the two visits using history, physical and MDM and bill at the appropriate level of care for both visits (obviously, it should be a higher visit since there are two significant problems).

10. The fees for not paying copays w/in 24 hours – are they posted in office? Is office covered in paper?
    Any communication relating to a practice's financial policy should be clearly stated and posted in the office as far in advance as possible.
    Fees for non-payment of copayments may be posted at the time of the service and then the charge deleted upon timely receipt of the co-payment eliminating the need for posting reminders to charge after 24 hours has passed.

11. How do you charge for 'nebulizer treatment' especially when the insurance says: "Not a Covered Service"?
    First, code a 94640 for the nebulizer treatment (using a nebulizer or metered dose inhaler). If you give more than one, use the -76 modifier on the second and subsequent codes. Given that most insurance companies do pay for nebulizer treatment, you should appeal in regard to coverage of this vitally important breathing treatment and see what criteria they use to determine why it is a non-covered service. Make sure you use the -25 modifier on the office visit to indicate that they are both separate services; without it they may be bundling the nebulizer.

12. What is a "realistic" discount you offer for self-paying patients?
    What is realistic for one practice may not be for another – though the range of discounts we see is as low as 10% and as high as 50% with it centering in the 20-25% range.

13. Should we also give patients discounts for those "processed through deductibles?"
    Definitely not. Not only would you be increasing the discount that you already agreed to with your contract, but doing so is very likely against the terms of your contract.

14. How can I find out if waivers are legal in my state?

An Advanced Beneficiary Notice (ABN) should be legal in every state as they are put out by Centers for Medicare and Medicaid services (CMS) and are to be used for Medicare patients. A waiver simply informs the patient that they may be responsible for a bill if it is found that it is a non-covered benefit. When the patients sign it, they state that they will be responsible for the bill. To confirm this, simply contact your state insurance commissioner.

15. Many of our payers require waivers at time of service to collect for uncovered services (like telephone services). How do you handle this since you don't know when you'll need the service? (General waiver doesn't work.)
    To answer this properly, we need to understand why a "general waiver" does not work – it should. Nonetheless, a non-covered service should not require a waiver as it is, by definition, excluded from the insurance contract.

16. How legal (or wise) is it to provide or deny services to your patients based on insurance coverage?
    Ultimately, you must consult your attorney on any legal or contractual questions. Note, however, that unless your state has specific laws addressing your insurance contracts, there is nothing *illegal* about, for example, telling your patients from Insurance Company A that they must go to the ER instead of your office after 6pm because Insco A does not cover after-hours work. It may against your *contract*, but that does not make it illegal.

17. How do you interpret what the age limit is for v20.2? Is it 0 up to the age of 17 years or 0 through the age of 17 years (up to 18 years)?
    For most carriers, a v20.2 covers 18 years of age, but it will vary depending on the carrier's loaded ICD-9 systems and their edits for age, gender, etc.

18. Telephone calls – can it be posted that parents have to pay if insurance doesn't?
    Essentially, if the insurance company states that phone calls are a non-covered service, you may bill the patient. If, however, the insurance company determines that phone calls are a service that is not billable and cannot be billed to the patient, you cannot bill them even if there is no payment at all.

19. What if patient is not verified on capitation list, patient pays fee-for-service. Next month patient is back capitated and you have to reimburse the patient?
    You should only need to reimburse the patient if it is confirmed that the patient

was covered by capitation during the time that you collected the fee-for-service fees. When you learn of a mistake like this, make sure that you confirm the true starting date of capitation coverage, as it often predates the visit data by a few months and you are owed capitation payments for more than the month in question.

20. How would you obtain a signed wavier for Telephone Service? I thought waivers were to be signed at time service is rendered.
 Waiver rules are difficult to pin down, as they can vary from state to state as well as from contract to contract. In many places, "general" waivers do, indeed, work just fine. Some offices indicate a waiver in their after-hours phone messages. Many of the systems who provide HIPAA secure email services also make patients click through a waiver (and even provide a credit card number!).

21. What documentation do you have that it is legal to charge different fee schedules for different companies?
 We have no documentation that it is *illegal* to charge different fee schedules for different private insurance companies. It likely breaks your contract, but that is quite different from illegal.
 You do need to be careful when it comes to charging Medicaid and Medicare patients differently. In effect, you must make sure to not charge them more than you charge other patients. The Office of the Inspector General keeps an eye out on this practice.
 From a practice management perspective, there are very few circumstances where charging multiple fee schedules benefits the practice.

22. Stand alone V-codes are typically not paid. For example, V71.4 (observation following other accident) ,V71.6 (Observation following other inflicted injury).How do I code V-codes to get paid?
 Many V-codes are payable, such as V30.0 for normal newborn, V20.2 for Healthy Child, or even V58.69 for Long term use of high risk medications. Some V-codes are not payable and each carrier makes that determination on its own. V-codes for vaccines are typically covered. Many V-codes are informational or screenings and may not be covered. When in doubt, consult your rep. ICD-9 offers guidance in the form of a grid to help users see which V-codes may appropriately be used as primary diagnoses – the introduction places V-codes into Primary, Primary or Subsequent, and Subsequent Only categories.

23. How can you use a waiver if you are not happy with contractual reimbursement amount? What about flu clinics?

If you are contracted with a carrier and are not happy with the reimbursement, you still have to file with them but you can appeal the amount of the reimbursement using the actual cost of the vaccine (cost per dose + 17-to 28% for storage, handling and shipping-according to the AAP) If you get a waiver you have to make sure the patient/parents understand that you are NOT going to file with their ins. co and that in fact this vaccine is strictly out of pocket. You can use a waiver to inform the patient that a service may or may not be covered and if it is not, it is their responsibility. This is different than what you are asking. Waivers don't allow you to bill the patient for the balance but informs the patient that they may be responsible for the whole amount.

When doing flu clinics you can have a sign stating that you will not be filing with insurance for the flu vaccine then you can collect any amount that you want to, it is basically all out of pocket.

24. We receive denials on "mental health" diagnoses, such as speech/language diagnoses, developmental delays, behavioral problems, etc. How can we overcome these denials? Should we contract w/our payers to include mental health or are these diagnoses typically a patient responsibility?
-and-
How do we get psychiatric diagnoses reimbursed? (Diagnosis such as anxiety, depression, ADHD)?

The primary reason you are denied for "mental health" diagnoses is because the codes 299.9 through 319.00 inform the carrier that the mental health portion of your patients' plans are responsible for paying for the service. Consequently, most carriers expect those codes only from psych services. If a carrier pays, it will often be at a lesser amount for you and a greater portion to the patient. This is due to the fact that many contracts have "50/50" mental health coverage. Some carriers don't cover mental health at all.

That does not mean all is lost! First, talk with the carrier and explain the necessity of a child to be seen by you, the PCP, as the you know and understand the child better than a psychiatrist will. Some plans have now started to recognize the clinical value of this response (Blue Shield of MI, for example) and will pay for E&M services with these diagnoses. If this position does not work, try taking it to the corporate offices of an insurance plan and have your medical director talk directly to the insurance medical director. Also be sure to enlist any parents you can find (and their employers), as any insurer will listen to them before a provider!

25. Should we contract with our payers to include mental health**?**

Expanding your clinical services to include the mental health care provides a greater clinical benefit to your patients in a number of ways. It also increases your value to the insurance companies. Although there are many other variables that affect this decision, it is worth considering.

26. My coders insist that no V codes are paid except for V20.2. How do we get them reimbursed?

    Your coders are probably exaggerating. Although each carrier may have a different set of V-codes that are payable, the vaccine-specific V-codes are almost always payable. V-codes for observation of a condition (specified) are also reimbursed. V58.69 (Long term use of high risk medication) rarely presents a problem.

    It is true that carriers may not cover screening V-codes (like for hearing and vision), but this has nothing to do with the ICD-9. V-codes can and should be used as appropriate. Many times they are a secondary diagnosis. Ultimately, your coders are referring to the non-covered services that often relate to the V-codes.

27. How do we get prolonged care codes reimbursed? Our coders tend to have to "write them off."

    First, ensure that you are billing your prolonged codes properly. Remember, they are add-on codes and cannot be billed by themselves; each code must be accompanied by a visit code. Do not forget that the time has to be documented as well. For example, say you spent 80 minutes in a visit – your HPI/MDM, etc., support a 99215 with an additional 35 minutes beyond the "normal" time you would spend.

    You would bill a 99354 along with the 99215. If denied, appeal with your documentation to demonstrate that indeed this visit was above and beyond the "normal" level of care and demand their reasons for denial. These codes have RVUs and should be payable. Remember, though: the visit must be at least 30 minutes longer than a normal visit at that level to be considered a "prolonged service."

28. How can we charge for time spent on phone coordinating care with judges, lawyers, etc?

    There are at least two ways to get credit for this effort: First, visits can be based on time as a key factor when counseling/coordination of care is performed face to face with the patient/parent. Second, remember that providing this type of service will certainly increase your medical decision making.

29. How can we charge for doing forms/writing letters for patients?

Depending on the type of form you are completing, there may be an associated code. For example, there is the 99080 for "Special reports or forms" (such as FMLA forms, life insurance, etc.) or a 96110/96111 for developmental testing. For other paper work, more and more practices are either charging on a per-item basis or adding minor annual "administrative fees" to the practice to cover the expense of these services. The upcoming Fall 2008 issue of the SOAPM newsletter will feature an article about this!

30. What can I do when carriers reject modifier -25 because they don't "recognize" it?
First, realize that any carrier telling you they don't recognize a -25 modifier is, at the least, pulling your leg. Nearly all carriers are "Medigap" carriers, which means that they receive Medicare claims as a secondary they certainly must recognize it then.
Still, what to do? If you are denied a visit at the same time as a procedure (not recognizing the 25) then you will have to appeal the denial with the documentation showing that indeed the visit was a very separate service and was needed to treat the patient for the presenting problems. Make sure you also indicate that the 25 modifier is a National Standard Modifier and is allowed in billing a claim.
You should also speak to your local AAP chapter and complete a Hassle Factor form:
<http://www.aap.org/moc/reimburse/hasslefactor/HassleForm.cfm>.

31. Do you charge/bill a co-payment for telephone encounters? During office hours? After office hours?
You really cannot determine whether a copay is due from a patient until you have billed the carrier or spoken with your rep. Chances are, it's a non-covered service, and therefore would not include a copay – but you could institute a fee of your own.

32. Do you have to write a progress note on a separate page for a -25 modifier or can you write at the bottom or back of preventive care page?
You can certainly write your second note just about anywhere – it just needs to be a distinctly separate service. At the very least, draw some solid lines mid-page as a break between the two. If two sheets can be utilized, it makes justifying the two visits easier.

33. How do we code for autism screening during a well visit?
If you follow the rules for the developmental codes (96110/96111) and complete a

proper screen, you should use those codes. Be sure that the physician documents the neuro-psych testing performed and the interpretation as well.

34. When doctor sees newborn in hospital, we charge for the hospital visit. When newborn comes to the office would we charge a new patient procedure? What if a different physician sees the patient?
Once the patient's chart is initiated in the hospital, the patient becomes an established patient for any provider in your office. When you see the patient in two or three days, it will be an established patient visit (99212 to 99215).

35. What is the ICD code for a pre-travel consult?
The best you can do in most circumstances is to use the V71.9 ("Observation without need for further medical care"), presuming that there are no signs or symptoms that you might otherwise diagnose. The vaccine specific codes for the travel diseases are also available if vaccines are administered.

36. What kind of documentation is necessary for telephone services? Should we start billing for telephone services even though payers in our area are not paying?
The telephone codes are time-based, so recording that data is important. Here is a sample telephone note:

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PC  C/O ears hurting, some fever.  Has had OM in past.
Offered appt and Mom said would go to urgent care.  Gave
advice concerning fever and control  and to come to office
for follow up if urgent determines has OM.  Total time in
call: 7 min.
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We recommend billing for telephone services, even if you will not be paid by your insurance companies (at first). Not only is tracking the volume of phone calls you take important for practice management purposes, the insurance companies will *never* start paying until you start billing them!

37. Service fees vs finance charges. Truth in lending disclosure?
State laws regarding finance charges, service fees, etc., vary significantly, so check with your local banking and insurance regulators. As a rule of thumb, adding "finance charges" to a bill obligates you to banking regulations in most, if not all states, the expense of which often eats up the value of the finance fees.

38. If contract states we must inform patients in advance of non-covered services, has anyone had success in getting such language removed? In our area, developmental screening falls in this category.
*Everything* is negotiable in your insurance agreements, no matter what the reps

tell you. It is all a matter of whether you say no or not! Use your patients to help communicate to the carrier how important this issue is.

39. How do you code for pre-op/driver's exam/camp or sports physical to get payers to cover in addition to annual checkup?
Unfortunately, there is no secret. If the carrier pays for only one physical a year, that is exactly what they will pay. Note, however, that a pre-op exam should probably be a *consult* code and is reimbursed differently (and often better!). Also, some driver exams may be reimbursed in full by employers requiring them.

40. What type of documentation is used when the 90465-90468 counseling codes are billed by the MD?
Physicians must document that they personally counseled the parents about the vaccines (listing the vaccines), that questions were answered and parents showed understanding.

41. How long is too long for filing claims? If service was done and complete, vaccinations given – should we fight until death to get insurance company to pay despite their claim filing criteria? What is reasonable?
Filing deadlines are both carrier and state specific – read your contracts and check with the state insurance commissioner. Once filed, however, fighting for what is rightfully yours and the length of time you spend doing that is totally up to the practice. Reasonable is entirely practice-specific – at some point, fighting for payment becomes more expensive than the payment itself is worth. Obviously, if this happens at any volume with a particular payer, you have to look at the bigger picture. That's when the hassle factor comes into play.

42. How else would you code for V65.5 ("Worried Well")? Code for symptom first? What if there are no symptoms, only a worried mom?
As a rule, it is usually beneficial to record any real symptoms first and foremost. If not, consider using the V71.9 (see above).

43. When a physician consults a 12-year-old girl and mom about Gardasil, is anyone coding 99401 ("Preventive Counseling") with V65.45 ("Counseling on other sexually transmitted diseases"), since 90465 is for age 8 and younger?
Good question! You could the 99401, but that code is based on time, so you must have at least 15 minutes of *documented* time spent counseling about Gardasil. Unfortunately, if the Gardasil is being done during a well check up, the counseling is included in the well check up at this time. We hope that in the future we will

have a counseling code for ages 9 and up.

44. How do we find out who the medical directors are?
 Presuming that you cannot find out that data (including contact information) from your rep, head straight for the carrier's WWW site. If that fails, try Google!

45. How would you bill for a child with several abscesses as a repeat procedure in global period. For Example, Day 1: I/D 1st abscess. On 3rd day, another abscess is ripe and needs drainage.
 Bill the office visit the first time with the first I&D (and a -25 modifier). After that, you should be able to bill the procedure, but including a cover sheet with an explanation should help a lot.

46. What CPT & ICD9 codes do you use for obesity nutritional counseling?
 You can always use the BMI V-codes (V85. range), the Obesity codes (278. range), or the excessive weight gain (V783.1 range) diagnoses codes, but the visit will be based on the amount of time spent counseling.

47. Do teachers concerned about ADD/ADHD count for a consult code?
 They sure can, as long as they write a letter asking for the evaluation. Make sure to have the parent sign a statement allowing you to share your evaluation – which is necessary for the consult code – as otherwise, it is a potential HIPAA violation.

48. How do you code a middle-of-the-night inpatient seen (or will be seen) by a call partner and charged by a subsequent hospital visit by that call partner?
 First, if you were called to the hospital to see the patient you can bill the 99053 code along with the appropriate subsequent hospital care code that you performed. The call partner will add to your note so that the level of care is totaled all together for one visit.

49. How do you code for a supply (such as a splint) that has been denied for DME?
 Explain to the insurance company that you are not a DME provider - you are a doctor's office. Use the codes from the HCPCS book.

50. How do you set your % of Medicare for RBRVS?
 We suggest using PCC's RVU Calculator (http://www.pcc.com/practmgmt/rvu.php) or the AAP's RVU brochure (http://www.aap.org/visit/rbrvsbrochure.pdf).

51. How are you tracking phone call charges to monitor when to submit claim based on global period, so you don't lose revenue?
When your physicians turn in their phone notes, someone must check to see if the notes relate to a pre- or post-op period. Many systems, including PMS and EHR, have tools to make this easier. Remember that that you cannot bill for any phone call that leads to a visit within 24 hours.

52. Should the newborn V-code be 1st or should I use a different illness code?
You should only use the V30 code when the infant has *no* other issues. Any illness related V-codes should be on your subsequent hospital codes. Do not use the sick diagnoses on a 99433 (subsequent NBN day) and do not use the V30 code on a 99231-99233.

53. What is the liability of the coding team? Can they add a handling code or check off a diagnosis recorded in chart but forgotten to be written by MD?
The bottom line to liability is simple: it is the physician's name on every claim that goes out and, as a result, he or she is responsible for what is on there. There is no particular problem when an employee adds a diagnoses or procedure, but any changes should be reviewed with the physician.

54. SOAPM article stated CRNP's can not code based on time. How to code then for the appointment for behavior when exam not really necessary? Do PE anyway? Then bill E/M? Bill under collaborating doc? Incident to requires doctor to see the child?
We couldn't find the referenced article here and operate under the assumption that NPs *can* bill based on time. Until we see information that says otherwise, we will continue to encourage time-based billing when appropriate.

55. Can you use 382.9 instead of 382.00 when it is a follow-up for otitis? 382.9/V67.59 instead of 382.00/V67.59.
A 382.9 is usually sufficient for diagnosis in an otitis follow up. The V67.59 is not necessary, as a rule.

56. Do you automatically submit paper claim with documentation?
*Never,* unless you believe that the claim will be denied and you want to prove the visit before the denial. Otherwise, only send documentation if requested.

57. Is there a code for performing orthostatic blood pressure and heart rate measurements?
No, it is part of the constitutional piece of the exam.

58. How do we know if a patient's plan requires a 2nd co-pay for the -25 modifier (and therefore we have to collect two copays)?
There is no sure-fire method to avoid this complication. The best you can do is collect the first co-pay and inform the parents that the carrier may determine that another co-pay is owed and they may receive a bill.

59. Can you use the telephone codes for non face to face non-physician services for our nurse triage done during regular business hours?
No - those services are considered “incident-to” the physicians' services. However, if the nurse takes call in the evening for the office, it is considered an extension of the office hours and can be billed using the non-physician provider call codes.

60. Do the telephone codes require a permanent storage of encounter like the on-line medical evaluation does?
Absolutely. Anything you bill you need to document.

61. Is coding for motivational interview for obesity coming?
We are not aware of any recent changes.

62. Are there any codes we can use for our lactation consultants we have in the office (our own nurses who are also certified lactation providers)? They spend anywhere from 15-60 minutes or more with new moms and their breast feeding issues.
You can find a really good review of the wide variety of options available to you for these visits at the AAP: <www.aap.org/breastfeeding/**CODING**.pdf >.

63. In addition to face to face, what about coordination of care? 2 or 3 phone calls, ER doc, specialist, fax record of visit to the above, etc.?
Time is a key factor when counseling *and/or* coordination of care is > 50% of the time spent face to face with the patient or family. If this work is done when the patient is still in the office, it can be counted.

64. Phone service codes – 99441, 2, 3 – do insurance carriers pay for these? If so, how much?
Some may, some may not - but that should not be your concern. What you need to do is inform parents ahead of time that these charges are going to happen and that they may or may not be covered and that they may or may not be responsible. Meanwhile, yes – some carriers pay for these codes!