



TOOL KIT FOR TEEN CARE
SECOND EDITION

BILLING AND CODING ISSUES
IN ADOLESCENT
REPRODUCTIVE HEALTH



THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

BILLING AND CODING ISSUES

Adolescent reproductive health presents many challenges to the obstetrician–gynecologist. Issues related to adolescent psychosocial development and interaction with the family of the adolescent patient present unique challenges not only in clinical care but also in billing. Consequently, providing care for adolescents often may require more physician time than that needed for adult patients. Despite these challenges, delivery of adolescent reproductive care can be rewarding for a variety of reasons. Initiation of care starts adolescents on the path of lifelong reproductive health, facilitates practice growth, and provides services to the daughters of patients typical of full-service obstetric and gynecologic practices.

Mastering the coding rules for Evaluation and Management (E/M) services is essential to obtaining appropriate compensation for physician time and effort devoted to adolescent health care. *Current Procedural Terminology* (CPT) coding rules for E/M services provided to adolescents are the same as those for other patients. There are some special circumstances (eg, extended visit times for counseling) that may occur more frequently for adolescent patients. *Current Procedural Terminology* guidelines for E/M services offer methods for accurately documenting and billing for these special circumstances. This document includes: a discussion of confidentiality issues, an overview of E/M coding for both problem-oriented and preventive care, a discussion of coding and billing challenges, and a billing quiz, including nine common scenarios found in adolescent health care. Please share these materials with your billing personnel.

CONFIDENTIALITY

Maintaining confidentiality for a minor patient often is a problem when billing for office visits and laboratory services such as pregnancy and sexually transmitted disease testing. Insurance companies and health maintenance organizations may not

reimburse for laboratory services described as “indicated routine screening,” and may insist that parents receive an itemized bill listing the specific tests. The disclaimer that “these tests are necessary in medical protocols” may be sufficient to satisfy the concerns of some parents. However, to ensure confidentiality some adolescents may choose to pay for these tests themselves. Some practitioners offer a reduced rate for these tests or refer patients to agencies that charge on a sliding scale according to income. However, if an insurer with whom the physician has a contract covers the service, allowing the patient to pay out-of-pocket could violate the terms of the contract because she is being denied a covered benefit. Office personnel should be cognizant of the issues of confidentiality with billing, reviewing claims with parents, and reporting laboratory results.

PROBLEM-ORIENTED OFFICE OR OUTPATIENT EVALUATION AND MANAGEMENT SERVICES

Key Components

Most E/M services require documentation of the key components of history, physical examination, and medical decision making to determine the level of service. Some E/M codes require all three of these key components, although others require only two. Sometimes face-to-face time spent with the patient can determine the level of service. See “Billing for Time Spent Counseling” in the following section entitled “Coding and Billing Challenges.” The different levels of service for these key components are defined as follows. For more information on E/M levels of service, refer to ACOG’s booklet, *CPT Coding in Obstetrics and Gynecology*, 2008.

Levels of History

The level of history is determined by four components: 1) the chief complaint; 2) history of present

illness; 3) review of systems; and 4) past, family, and social history. These components are defined in the “Quick Reference Card on Coding” in this folder of the kit. A chief complaint is required for all levels, but requirements for the other components vary as shown in Table 1.

Levels of Physical Examination

According to CPT rules, the number of body areas and organ systems examined determines the level of physical examination. The specific body areas and organ systems are defined on the “Quick Reference Card on Coding” in this folder of the kit. They also are listed in the American Medical Association’s *CPT® 2008*, Standard Edition in the guidelines for E/M services section. The levels of examination are shown in Table 2.

Levels of Medical Decision Making

The level of medical decision making is determined by three components: 1) number of diagnoses or management options, 2) amount or complexity or both of data reviewed, and 3) risk of complication and morbidity or mortality. Two of these three elements must be met or exceeded in order to report a level of medical decision making. The requirements for the different levels are shown in Table 3.

Determining Office or Other Outpatient Levels of Service

New patient office or outpatient visits require three of the key components (history, physical examination, and medical decision making), while established patient office or outpatient visits require only two key components (see Tables 4 and 5).

Table 1. Levels of History

Levels of History	Components of History			
	Chief Complaint	History of Present Illness	Review of Systems	Past, Family, and Social Histories
Problem focused	Required	Brief	Not required	Not required
Expanded problem focused	Required	Brief	Problem pertinent	Not required
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

Table 2. Levels of Physical Examination

Levels of Physical Examination	Current Procedural Terminology Definition
Problem focused	Limited examination of affected body area
Expanded problem focused	Limited examination of affected body area AND other symptomatic or related organ systems
Detailed	Extended examination of affected body area AND other symptomatic or related organ systems
Comprehensive	General multisystem examination OR complete examination of single organ system

Table 3. Levels of Medical Decision Making

Levels of Medical Decision Making	Number of Diagnoses or Management Options	Risk of Complications or Morbidity or Mortality	Amount or Complexity of Data or Both to be Reviewed
Straightforward	Minimal	Minimal	Minimal or none
Low complexity	Limited	Low	Limited
Moderate complexity	Multiple	Moderate	Moderate
High complexity	Extensive	High	Extensive

Table 4. Outpatient Problem Visit, New Patient

Key Components	Code 99201	Code 99202	Code 99203	Code 99204	Code 99205
History	Problem focused	Expanded problem focused	Detailed	Comprehensive	Comprehensive
Physical examination	Problem focused	Expanded problem focused	Detailed	Comprehensive	Comprehensive
Medical decision making	Straightforward	Straightforward	Low complexity	Moderate complexity	High complexity
Key components required	All three	All three	All three	All three	All three
Face-to-face time	10 min	20 min	30 min	45 min	60 min

Table 5. Outpatient Problem Visit, Established Patient

Key Components	Code 99211	Code 99212	Code 99213	Code 99214	Code 99215
History	Not required	Problem focused	Expanded problem focused	Detailed	Comprehensive
Physical examination	Not required	Problem focused	Expanded problem focused	Detailed	Comprehensive
Medical decision making	Not required	Straightforward	Low complexity	Moderate complexity	High complexity
Key components required	None	Two of three	Two of three	Two of three	Two of three
Face-to-face time	5 min supervision*	10 min	15 min	25 min	40 min

*Physician must be in the office during the evaluation and management service.

PREVENTIVE MEDICINE SERVICES

Preventive E/M services are provided for patients who have no current symptoms or diagnosed illnesses. These services include an age and gender appropriate comprehensive history and physical examination, counseling, anticipatory guidance, risk factor interventions, discussions about the status of previously diagnosed stable conditions, and discussions about issues related to the patient's age or lifestyle. These codes do not include a chief complaint, medical decision making, or a typical time. The correct code is determined by the patient's age and whether or not she is a new or established patient. The codes reported for adolescents are shown in Table 6. A comparison between coding and documentation requirements for problem-oriented visits and preventive visits can be found in Table 7.

CODING AND BILLING CHALLENGES

The American College of Obstetricians and Gynecologists Committee on Adolescent Health Care surveyed a small focus group of practicing Fellows on billing scenarios common to adolescent gynecology. Billing experts reviewed these responses and noted several areas of confusion and billing errors.

1. Noncovered Services

Many services will not be covered by the patient's insurer. Adolescent patients may be less familiar with their insurance benefits than adults and may not realize that some health care services are not covered. Patients and their families sometimes assume that if a claim comes back as noncovered, the physician's office must have made a "billing error." The important burden of explaining to patients that a particular service is not covered under the patient's insurance plan is placed upon the office

Table 6. Preventive Medicine Visits

Description of Preventive Visit	Evaluation and Management Code
New patient visit, age 12–17 years	99384
New patient visit, age 18–39 years	99385
Established patient visit, age 12–17 years	99394
Established patient visit, age 18–39 years	99395

Table 7. Comparison Between Problem-Oriented Evaluation and Management Services and Preventive Services

Issue	Problem-oriented Evaluation and Management Services	Preventive Evaluation and Management Services
Patient status	Some services include different codes for new and established patients	All services include different codes for new and established patients
Location of services	Some services include different codes for inpatient and outpatient	Same codes used for any site of service
Type of service	Different codes for consultations, observation, prolonged services, and critical care	One type of service
Time component	Most codes include a time component	No time component included
<i>Documentation Required</i>		
Key Components	Most codes include history, physical examination, medical decision making	All codes use history and physical examination only
Elements in history component	Chief complaint; history of present illness; review of systems; and past, family, and social histories	Review of systems and past, family, and social histories only
Elements in physical examination component	Examination of affected body areas or organ systems plus other areas depending on level of service	Multisystem examination—extent depends on patient's age and risk factors
History and physical examination levels of service	Codes may include problem focused, expanded problem focused, detailed, and comprehensive levels of service	All codes include a comprehensive history and examination that are age and gender appropriate

staff. In most situations, noncovered services can be billed directly to the patient but sometimes this is specifically prohibited under the patient’s plan. A patient or her family should be informed in advance that they will be responsible for payment because a service is not covered. Do not alter correct codes in order to obtain payment from third-party payers for services that are not covered by the patient’s policy.

2. Referral Versus Consultation

The terms “referral” and “consultation” often are misunderstood. All consultations are referrals, but not all referrals are consultations. Consultations must meet strict criteria as outlined in the CPT manual. A consultation is a request for an opinion or advice from another physician or other appropriate source. The consultant’s opinion must be communicated to the requesting physician. Both the request

and the opinion or advice must be documented. A physician consultant may initiate diagnostic or therapeutic services or both at the same visit as the consultation. For example, a pediatrician may ask a gynecologist for his or her opinion about possible causes and treatments of a patient’s dysmenorrhea. The gynecologist may examine the patient and perform a procedure in order to diagnose the cause of the problem. Both the procedure and the E/M service are reported. A modifier 25 is added to the E/M code. This modifier is discussed in the following section. If the requesting physician asks the consultant for his or her opinion or advice on the same patient a second time, this visit is reported using another outpatient consultation code. If the consultant initiates a follow-up visit, this visit is reported using established patient E/M services codes (99211-99215).

An office referral often is used to indicate that one physician requests that another physician take over responsibility for management of an aspect of a patient’s care. For example, a pediatrician may refer a 19-year-old woman to a gynecologist for a pelvic examination because the pediatrician does not perform these types of examinations. This is not a consultation because the pediatrician is not seeking advice or an opinion. The different levels of service for consultation services are described in Table 8. Consultation codes reflect greater remuneration because of the increased physician work involved. When a service meets the consultation criteria, use the appropriate consultation code.

3. Use of Modifier 25

The obstetrician–gynecologists surveyed seldom used modifiers from the CPT code book, although they were often appropriate. This includes use of modifier 25 to report a significant and separately identifiable E/M service by the same physician on the same day of a procedure or other service. (See “Scenario One” and “Scenario Eight” in the “Billing Quiz.”) These E/M services must be documented with a level of history, examination, and medical decision making that is above and beyond the usual services provided before or after a procedure. For example, the physician may see a patient; perform a history, examination, and medical decision making; and, based on his or her findings, decide to perform a procedure during that same visit. Another example is the physician who sees a patient for a planned procedure and finds another problem that requires additional history, examination, and medical decision making during the visit. In either of

these cases, an E/M service code may be reported with a modifier 25 as well as the code for the procedure.

4. Current Procedural Terminology

Prolonged Services

Prolonged services codes (99354–99357) were seldom used by survey respondents, although these codes may be appropriate in some adolescent visits. (See “Scenario Two” in the “Billing Quiz.”) Prolonged services can be billed when the clinician provides face-to-face services at least 30 minutes beyond the “typical time” listed in the E/M code being reported. These services may include counseling. The medical necessity for the prolonged services must be well documented in the record. These codes (listed in Table 9) may only be reported with E/M services that list a “typical time” in the code description, such as outpatient services, inpatient services, and most consultation codes. Prolonged services may not be reported with E/M services that do not list a “typical time,” such as preventive services, observation care, and inpatient care. Clinicians need billing forms that allow room for a short written description of the reason that the prolonged services were medically necessary. (See comments in “Scenario One” and “Scenario Two” in the “Billing Quiz.”) For example, if a patient is seen for 95 minutes beyond the typical time listed in the E/M code being reported, the physician reports the appropriate E/M code plus code 99354 (for the first 74 minutes of prolonged services) plus code 99355 (for the remaining 21 minutes). However, if a patient is seen for 85 minutes beyond the typical time listed in the E/M code being reported, the physician

Table 8. Initial Office or Other Outpatient Consultations

Key Components	Code 99241	Code 99242	Code 99243	Code 99244	Code 99245
History	Problem focused	Expanded problem focused	Detailed	Comprehensive	Comprehensive
Physical examination	Problem focused	Expanded problem focused	Detailed	Comprehensive	Comprehensive
Medical decision making	Straightforward	Straightforward	Low complexity	Moderate complexity	High complexity
Key components required	All three	All three	All three	All three	All three
Face-to-face time	15 min	30 min	40 min	60 min	80 min

reports the appropriate E/M code plus code 99354 (for the first 74 minutes of prolonged services). Because the remaining time is only 10 minutes, code 99355 is not reported.

See the American Medical Association's *CPT® 2008*, Standard Edition for more information on use of these codes. Although CPT also contains codes for "non-face-to-face" prolonged services, few if any insurers reimburse for these codes.

5. Billing for Time Spent Counseling

Counseling in the office can be billed when more than 50% of the visit is spent in physician face-to-face counseling or physician face-to-face coordination of care or both. The level of service is determined by the total time spent with the patient. The nature and extent of the counseling must be documented in the chart as well as a documented estimate of length of visit. Counseling must be face-to-face with the patient. The family also can be present.

Counseling is defined as a discussion with a patient or her family about:

- Diagnostic results, impressions or recommended studies;
- Prognosis;
- Risks and benefits of management (treatment) options;
- Instructions for management (treatment) or follow-up;
- Importance of compliance with chosen management (treatment) options;
- Risk factor reduction; and
- Patient and family education.

The assumption that counseling is not billable relates to noncovered versus covered services. For example, some insurance plans do not cover office visits reported with only "V" diagnostic codes. These diagnoses are reported for visits when the patient is not currently sick or injured (eg, the patient is seen only for screening for sexually transmitted diseases, diagnostic code V74.5). Therefore, counseling provided during this visit is not billable to these third-party insurers.

In contrast, insurers may accept billing for counseling linked to ICD-9-CM codes that are

covered under their insurance plan. For example, in "Scenario Four" in the "Billing Quiz," the entire visit time is spent in face-to-face counseling for a patient with cervical dysplasia. No examination is performed. The E/M visit code reported is determined by the time spent counseling linked to ICD-9-CM code 622.12 (moderate dysplasia of the cervix). Table 5 lists the typical face-to-face time for these established patient E/M codes.

CODING RESOURCES

There are many coding services and publications available that can help answer questions on coding. The following publications can be ordered by calling (800) 762-2264 or by visiting sales.acog.org:

- *CPT Coding in Obstetrics and Gynecology 2008* provides basic information about how CPT codes are used. It is published biennially by ACOG and sent free of charge to each ACOG member. Yearly code changes and tables describing the various types and levels of E/M codes are included. A supplement to this booklet is sent to members in alternate years. Additional copies of the booklet can be ordered.
- *The Essential Guide to Coding in Obstetrics and Gynecology*, Third Edition. This publication, updated in 2008, includes information from ACOG's coding workshop syllabus and other ACOG coding resources in a workbook format. The book covers coding diagnoses and procedures, E/M Services, gynecologic surgery, obstetric services, ultrasound procedures, services to Medicare patients, and preventive care. Other chapters discuss the use of modifiers and dealing with third party payers. This book is revised in even numbered years.
- *ICD-9-CM Abridged Diagnostic Coding in Obstetrics and Gynecology, 2008* includes diagnosis codes most often reported by obstetrician-gynecologists in a pocket-sized, more portable format than the complete ICD-9-CM publication. This publication mirrors the format of the complete ICD-9-CM book. This book is revised annually.

- *Frequently Asked Questions in Obstetric and Gynecologic Coding*, Third Edition, 2007 includes often-asked coding questions received from ACOG Fellows over the past few years and answers from ACOG's Committee on Coding and Nomenclature. This book is updated biennially.

ACOG also offers a series of coding workshops for physicians and their staff nationwide. The sites and dates of these courses can be found on the ACOG web site (www.acog.org) or by calling (202) 863-2498. Specific coding questions can be faxed to the ACOG Coding and Nomenclature Department at (202) 484-7480 or sent via e-mail to coding@acog.org.

GENERAL SUGGESTIONS FOR BILLING PERSONNEL

1. The coding resources American Medical Association's *CPT® 2008*, Standard Edition and ACOG's *ICD-9-CM Abridged Diagnostic Coding in Obstetrics and Gynecology*, 2008 should be readily available at every site where the obstetrician–gynecologist sees adolescent patients.
2. The “explanation of benefits” received from insurers with payments should be reviewed each month. This review often will reveal incorrect billing and coding practices and variations in coverage and coding requirements among insurers.
3. Billing forms should have a designated space for clinicians to explain the reason for use of a modifier or a prolonged visit code. The designated space need only allow enough room to succinctly summarize the issue and reference the chart.

BILLING QUIZ

Nine scenarios are included in this quiz and represent a variety of clinical outpatient adolescent reproductive visits. These scenarios offer examples of possible appropriate coding, and their inclusion is not meant to imply that they are the only solutions or correct coding for a particular scenario. It is suggested that readers “test” their coding knowledge by trying to code each scenario, using the information in the tables found in the previous section.

Quiz yourself, using Tables 1–9, on how you would code for these services. Answers constructed by coding experts can be found at the end of scenario nine. Sometimes the E/M service code listed in an answer ends in an “X.” This is done to indicate that the level of service depends on the care delivered by the physician.

QUESTIONS

Scenario One

A 15-year-old sexually active patient is seen in your office for the first time for preventive care. How do you bill for the visit?

Scenario Two

A 16-year-old new patient with amenorrhea is seen in your office and given a comprehensive history and examination with high complexity medical decision making. You diagnose an eating disorder, severe bradycardia, hypotension, and hypothermia and determine that the patient requires hospital admission. You do not admit the patient to the hospital, but you facilitate her admission to the eating disorder unit of the hospital to which you refer. You spend 1 hour and 40 minutes with the patient and her mother. How do you code for this visit?

Scenario Three

You prescribe birth control pills to a teenaged patient and want to see her for follow-up in 1 month for a compliance check. How do you code for the follow-up visit assuming that a physical examination is not done at her return visit?

Scenario Four

You perform a colposcopy on a 17-year-old patient. The biopsy reveals moderate cervical dysplasia. Your practice is to review the results with the patient in the office. You meet with both the patient and her mother in your office. The mother is extremely anxious and concerned. You do not re-examine the patient during the visit but counsel the patient and her mother for 45 minutes. How do you code for this visit?

Scenario Five

A 17-year-old patient with health maintenance organization (HMO) insurance coverage calls and says she has been “referred” by her pediatrician for a gynecologic examination. She does not need a referral form for preventive care. However, when she actually comes to the office, she needs an examination for menstrual irregularity. This is a problem that would require a referral form from her HMO. Your office tries to contact the primary care doctor, but the line is busy. If you elect to proceed with the visit, how do you code for it?

Scenario Six

A 17-year-old new patient to the practice needs a visit for preventive care. Her insurance carrier does not require a referral for this service. In addition to preventive care, however, she has a significant menstrual irregularity. She has a referral form from her pediatrician, which is required by her insurance carrier for any problem visit. You elect to take care of both the menstrual irregularity and the preventive care at the initial visit. How would you code for this?

Scenario Seven

You call a patient and her mother to review the findings of the patient’s amenorrhea workup. Both have multiple questions and you spend 30 minutes on the telephone. Can you bill for this call? If so, what code do you use?

Scenario Eight

A 17-year-old patient is scheduled for a colposcopy in your office for mild cervical dysplasia. On the day of colposcopy, she also complains of a breast mass. You complete the colposcopy with biopsy, then take a breast history, perform a breast examination, and discuss the findings and plan with the patient. How do you code for this visit?

Scenario Nine

A 16-year-old patient is scheduled for a Depo-Provera injection. A nurse provides this treatment to her. She does not see a physician during this visit. How do you code for this visit?

ANSWERS

Scenario One

A 15-year-old sexually active patient is seen in your office for the first time for preventive care. How do you bill for the visit?

Current Procedural Terminology Code

99384 (new patient preventive care visit, age 12–17 years)

Diagnostic Code

V72.31 (annual routine gynecologic examination)

Comments

If the patient was seen for a preventive visit but also was tested or treated or both for a sexually transmitted disease or treated for an unrelated condition, the physician may be able to report code 99384 plus a problem E/M visit code with a modifier 25. This can be done if the examination and history performed in the evaluation of the problem was significant and distinct from the preventive examination and history. The significant additional work must be documented in the patient's record. If it was not significant, then only the preventive code can be reported. Note that if the patient was given a prescription for oral contraceptives, no additional service is reported. Discussions about birth control options or other issues related to the patient's age or lifestyle are not reported separately. If, however, she is fitted for a diaphragm or an intrauterine device or if Norplant is inserted, the appropriate procedural code may be reported. In this case, report the procedural code and the preventive code with a modifier 25.

Scenario Two

A 16-year-old new patient with amenorrhea is seen in your office and given a comprehensive history and examination with high complexity medical decision making. You diagnose an eating disorder, severe bradycardia, hypotension, and hypothermia and determine that the patient requires hospital admission. You do not admit the patient to the hospital, but you facilitate her admission to the eating disorder unit of the hospital to which you refer. You spend 1 hour and 40 minutes with the patient and her mother. How do you code for this visit?

Current Procedural Terminology Codes

99205 (comprehensive new outpatient problem visit) and
99354 (prolonged services)

Diagnostic Codes

307.50 (eating disorder, unspecified), 427.89 (bradycardia),
458.9 (hypotension, unspecified), 780.99 (hypothermia).

Comments

Codes 99354–99357 are appropriate for physicians who provide prolonged services with direct patient contact beyond the usual service (see Table 9). Prolonged services cannot be reported unless the E/M has a time component. Prolonged services must exceed the average time for the specific E/M code by 30 minutes. In this case, the typical time for 99205 (comprehensive initial outpatient problem visit) is 60 minutes. A total of 100 minutes was spent with the patient and her mother. Therefore, you can bill for 40 minutes of prolonged time. The diagnoses support the need for a high level of E/M code, a prolonged encounter and the patient's hospitalization.

Scenario Three

You prescribe birth control pills to a teenaged patient and want to see her for follow-up in 1 month for a compliance check. How do you code for the follow-up visit assuming that a physical examination is not done at her return visit?

Current Procedural Terminology Code

The E/M code is controlled by time when patient counseling is more than 50% of the total face-to-face encounter. Therefore, if the return visit took a total of 25 minutes, the code would be 99214; if the visit took 15 minutes of face-to-face time, the code would be 99213 (see Table 5). It is important to note that it is not necessary to meet the level of examination described for the E/M code because time alone is used to determine the correct code. It is important to document in the record the time spent with the patient and the topics discussed.

If time were not the prevailing component (that is, less than 50% of the physician time was spent counseling the patient), then an E/M code would be reported according to the key components of history, examination, and medical decision making.

Diagnostic Code

V25.41 (surveillance of previously prescribed contraceptive methods, contraceptive pill) if no additional problems are evaluated during the visit.

Comments

If the patient has a specific problem, such as breakthrough bleeding, other ICD-9-CM codes, such as 626.4 (irregular menstruation), may be appropriate. It is important to check the patient's insurance coverage. If birth control is a noncovered benefit, the physician should bill the patient. If the patient is not having any problems (that is, the only diagnostic code that can be reported is a V code), then the visit may not be covered even if the patient has coverage for birth control.

Scenario Four

You perform a colposcopy on a 17-year-old patient. The biopsy reveals moderate cervical dysplasia. Your practice is to review the results with the patient in the office. You meet with both the patient and her mother in your office. The mother is extremely anxious and concerned. You do not re-examine the patient during the visit but counsel the patient and her mother for 45 minutes. How do you code for this visit?

Current Procedural Terminology Code

99215 (comprehensive established patient visit)

Diagnostic Code

622.12 (moderate cervical dysplasia)

Comments

This scenario follows the same rule as described in "Scenario Three." The typical time listed for 99215 (comprehensive established patient visit) is 40 minutes (see Table 5). Time becomes the controlling factor in choosing the appropriate E/M code when counseling or coordination of care constitutes greater than 50% of the face-to-face time. The extent of counseling, including time spent, must be documented in the chart. If time were not the prevailing component (that is, less than 50% of the physician time was spent counseling the patient) then an E/M code would be reported according to the key components of history, examination, and medical decision making.

Scenario Five

A 17-year-old patient with health maintenance organization (HMO) insurance coverage calls and says she has been "referred" by her pediatrician for a gynecologic examination. She does not need a referral form for preventive care. However, when she actually comes to the office, she needs an examination for menstrual irregularity. This is a problem that would require a referral form from her HMO. Your office tries to contact the primary care doctor, but the line is busy. If you elect to proceed with the visit, how do you code for it?

Current Procedural Terminology Code

See comments.

Diagnostic Code

See comments.

Comments

The term "referral" often is used loosely by patients and even office personnel. Patients actually may mean, "My primary care provider wanted me to see a gynecologist."

"Nonapproved" consultations or "nonapproved" problem visits for patients in HMOs or insurance plans that require a primary care physician referral often are a significant cause of uncollected bills. Some standard office procedures should help prevent this all too common scenario.

During the initial telephone call, the office staff should carefully note the exact reason for which an appointment is scheduled. Adolescents and their parents may not understand that a "routine visit" is not for a problem. This should be discussed with them during the initial telephone call. The services that are covered and not covered by the patient's insurance carrier should be reviewed with the patient.

Charts should be marked clearly to indicate whether the patient is being seen for a consultation, referral, or routine care. Office staff always should check to see that appropriate referrals are in the chart before the patient is placed in the examination room. Keep in mind that although all consultations are referrals, all referrals are not consultations. *Current Procedural Terminology* coding clearly distinguishes between problem visits and consultations and includes strict criteria that must be met for consultations.

If, as in this scenario, the patient has a problem and only has approval for a preventive care visit, the gynecologist should assess the situation and

take action. Some insurers will approve a retroactive referral form if office staff contacts the insurer via fax or a telephone call and explains the situation. If the problem is nonemergent and the patient also needs a routine preventive visit, the physician may elect to provide a preventive visit at that time and schedule another visit to evaluate the menstrual problem.

Scenario Six

A 17-year-old new patient to the practice needs a visit for preventive care. Her insurance carrier does not require a referral for this service. In addition to preventive care, however, she has a significant menstrual irregularity. She has a referral form from her pediatrician, which is required by her insurance carrier for any problem visit. You elect to take care of both the menstrual irregularity and the preventive care at the initial visit. How would you code for this?

Current Procedural Terminology Codes

Some third-party payers will reimburse for both a preventive and problem visit code on the same day; others will not. If they do reimburse for both, then appropriate billing would include code 99384 for the preventive visit and code 9920X-25 for the E/M service that dealt with the menstrual irregularity. Note that the code for the problem E/M service requires a modifier 25. This tells the insurer that the problem evaluated was significant and separately identifiable from the preventive service. The E/M code will be selected based on the level of history, examination, and medical decision making required to evaluate the menstrual irregularity (see Tables 1–3).

If, however, the insurer will not reimburse for both codes, the provider has two options. The first option is to bill only for the service (either the preventive or the problem-oriented portion of the visit) that took the most time and physician work during the visit or, if allowed under the insurer's contract, bill the patient for the uncovered part of the visit and the insurer for the covered part. The second option is for the physician to deal with the menstrual irregularity during this visit and ask her to return to the office for a separate preventive visit.

Diagnostic Code

Code V72.31 (annual routine examination) is linked to preventive code 99384 and code 626.4 (menstrual irregularity) is linked to problem-oriented E/M code 9920X.

Comments

If the physician bills two separate E/M codes, significant and separate services must have been rendered and the chart must document these services. Separate notes (one for the preventive service and

one for the problem-oriented service) are appropriate. A line could be drawn in the chart to differentiate between the two services.

Alternatively, practices may find forms helpful. Routine forms for preventive care visits and frequent problem visits will shorten the documentation time and clearly document the separate services rendered. Common problem visit forms can be designed for problems such as menstrual irregularity, pelvic pain, and vaginal discharge.

Practices may find it helpful to generate a list of third-party payers in their area that will accept two separate E/M codes on the same day of service and those that will not.

Scenario Seven

You call a patient and her mother to review the findings of the patient's amenorrhea workup. Both have multiple questions and you spend 30 minutes on the telephone. Can you bill for this call? If so, what code do you use?

Current Procedural Terminology Code

See comments.

Diagnostic Code

See comments.

Comments

Although there are E/M codes for telephone calls (99441–99443), this service is almost never paid for by third-party payers. However, in most situations providers can bill patients for these services, but this is not done often. If practices elect to bill patients for these services, it is critical that patients understand beforehand that they will be billed.

Given the above limitations and because face-to-face counseling often is more effective, many physicians elect to bring patients back into the office for any counseling requiring more than a few minutes on the telephone. An appropriate E/M code, in this scenario, would be determined by time. For the 30 minutes spent discussing findings in this scenario, report code 99214 (detailed established outpatient problem visit) with ICD-9-CM code 626.4 (menstrual irregularity).

Scenario Eight

A 17-year-old patient is scheduled for a colposcopy in your office for mild cervical dysplasia. On the day of colposcopy, she also complains of a breast

mass. You complete the colposcopy with biopsy, then take a breast history, perform a breast examination, and discuss the findings and plan with the patient. How do you code for this visit?

Current Procedural Terminology Codes

Procedural code 57455 (colposcopy with biopsy) and E/M service code 9921X with a modifier 25 (significant and separately identifiable E/M by the same physician on the same day of service).

Diagnostic Codes

Code 622.11 (mild cervical dysplasia) linked to the procedure code and 611.72 (breast lump or mass) linked to the E/M service.

Comments

Coding errors are common in this scenario. Physicians often code incorrectly for the colposcopy procedure and an established patient office visit for the breast mass, omitting the modifier 25. Linking the procedure code and diagnostic code as described is important. As in “Scenario Six,” distinct and separately identifiable services must be documented. The clearest way to do this is to generate separate notes for the visit and the procedure rather than to mix the history and physical examination for the breast mass and colposcopy procedure note in the chart. A colposcopy note, for example, could be followed by a problem visit form documenting the breast history, physical, analysis, and plan.

Scenario Nine

A 16-year-old patient is scheduled for a Depo-Provera injection. A nurse provides this treatment to her. She does not see a physician during this visit. How do you code for this visit?

Current Procedural Terminology Codes

Code 90772 (therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular) if a physician is providing direct supervision at the time of the injection plus either code 99070 (CPT drug supply) or code J1055 (Health-

care Common Procedure Coding System [HCPCS] code for Depo-Provera, 150 mg, for contraceptive use).

Diagnostic Code

Code V25.8 (other specified contraceptive management)

Comments

Current Procedural Terminology states that code 90772 cannot be reported if the nurse is giving the injection without direct physician supervision. The supervising physician must be in the office suite when the nurse gives the injection. If there is no physician supervision, then report only 99211.

If code 99211 is reported, the nurse would need to document the encounter in the record. This will include documenting the reason for the visit, the procedure performed, a note regarding observation (if any) following the injection, and any plans for a return visit. If the code 90772 is billed instead of code 99211, only the fact that the patient received an injection needs to be documented. In addition, the cost of the drug product injected always is billed using either CPT code 99070 or HCPCS code J1055. The choice of code will depend on what the payer’s computer system can accept. Only some non-Medicare payers can process HCPCS alphanumeric codes. If the CPT code 99070 is reported, the dosage and drug name should be included on the claim. It also is a good idea to indicate the National Drug Code (NDC) found on the package insert. The use of this number may expedite processing.

Coding for injections varies greatly by payer. Offices should contact the payer to determine whether the particular injection is a covered benefit under the patient’s insurance and how the payer wants the injected drug reported.

