CODING Q&A

Code Compliantly But Differently, Based on the Payor

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Q. I have been told that I can get credit for a complete review of systems (at least 10 systems) by simply noting positive findings in certain systems and then noting "all other systems negative."

A. This is, indeed, a general CMS "guideline," but two Medicare carriers have issued contradictory guidelines. TrailBlazer Health Enterprises (Medicare carrier for Delaware, the District of Columbia, Maryland, Virginia, and Texas) and Wisconsin Physicians Services (Medicare carrier for Illinois, Michigan, Minnesota, and Wisconsin) have issued directives that the provider must specify the actual systems that are negative (Trailblazer) or that specifically disallow coding credit for use of the phrase "all other systems negative" (Wisconsin Physicians Services).

In mid-November, Wisconsin Physicians Services reverted back to allowing the "all other systems negative" phrase. Since the situation is still in flux, physicians should consider revising their documentation procedures in order to avoid challenges to their E/M claims.

Many payors continue to give credit for the "all other systems negative" notation. It is my opinion, however, that making specific notations on each appropriate system is a better procedure from both a clinical and a compliance standpoint.

Q. When a patient returns to the urgent care center for an injection of an antibiotic a day after being seen by the physician for an infection, can we bill a 99211 for the nursing services?

A. Yes. CPT guidelines allow coding a 99211 for an injection given without direct physician supervision. Medicare's incident-to billing guidelines, however, require direct physician supervision if 99211 is coded. Thus, you may not use this code to bill any payor that follows Medicare's incident-to guidelines for an injection given without direct physician supervision.

If the injection was provided by a midlevel provider following a treatment plan previously documented by a physician who had devised this plan as part of a face-to-face encounter with a patient, then an appropriate E/M may be billed under the physician provider number. If the midlevel provider administers the injection but is *not* following a specific plan outlined by the physician as part of a previous patient encounter, then the E/M must be reported under the midlevel provider's number.

Q. How do we code for patient visits that are limited to gynecological exams and screening Pap smears?

A. The answer varies, based on the payor being billed. If you are billing Medicare, use code G0101 to code a pelvic and breast examination. Medicare will reimburse for this code once every two years for low-risk patients (those with diagnosis V76.2, V76.47, V76.49). For high-risk patients, Medicare will reimburse once per year. To document this high risk, use diagnosis code V15.89.

Likewise, Medicare will pay for Pap smear screening once every two years for low-risk patients and once per year for high-risk patients. For specimen collection and preparation, code with Q0091. Use G0124, G0141, or P3001 for test interpretation. Use V72.31 as the ICD-9 code for a screening Pap and full gynecological exam.

If you are not billing Medicare, the rules may be quite different, and the payor may require codes 99381-99397 for a screening gynecological exam and Pap smear. Some private payors accept code 99000 for specimen preparation and transfer to the lab.

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