Back to Basics: Coding for Physician Services

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How many times have you asked the question "How do you code ___?" We never seem to have all of the answers involving new techniques or unusual cases. With accurate, correct data so critical, it is vital that we know the answers. Included in this article are several commonly asked questions with answers for coding physician professional services.

Question: We are performing a new procedure involving the use of glue to close the skin. How do we code the use of dermabond to close the skin?

Answer: CPT Assistant has reviewed its original advice on this issue. Many different opinions have been published in various publications on this topic. And the authors giving advice are providing answers that could have an impact on reimbursement and increase payment. However, since CPT Assistant has given its new advice, the correct code to use is a simple closure code of the skin with the correct site coded. This replaces the advice previously published—to use the unlisted procedure code. The rules of closure are still followed, and if intermediate or complex repairs are done, they are coded without any additional reporting of the adhesive repair.

Answer: The National Correct Coding Initiative (NCCI) was implemented by the Health Care Financing Administration (HCFA) to promote correct coding throughout the US, and to help physicians correctly code services for payment. There are a series of edits that will be applied to each claim. The NCCI edits, available in printed or electronic formats, can be ordered from the National Technical Information Service (NTIS) at (800) 363-2068, or www.ntis.gov. Chapters based on specialty are also available.

Question: What ICD-9-CM diagnosis code would a physician use when he or she is called to the long term care facility because a patient is found sitting on the floor? The physician sees the patient, but no injuries are found.

Answer: The observation and evaluation codes (V71.0-V71.9), Suspected condition not found, are appropriate.

Question: The patient is treated in the cancer center for placement of radiation implants. What is the correct ICD-9-CM diagnosis code?

Answer: If the patient is treated for the placement of radioactive implants, assign the malignancy as the diagnosis. The implants are separate and are coded differently than a patient treated with radiation therapy. For a patient treated with radiotherapy, assign V58.0 plus the code for the malignancy.

Question: When a physician removes a foreign body from the skin and/or subcutaneous tissue, but does not use an incision, what code is reported for this service? For example, what if a patient shoots himself with a nail gun and the nail must be pulled out? A local anesthetic is administered and the wound is dressed, but no incision is made.

Question: When a physician removes a foreign body from the skin and/or subcutaneous tissue, but does not use an incision, what code is reported for this service? For example, what if a patient shoots himself with a nail gun and the nail must be pulled out? A local anesthetic is administered and the wound is dressed, but no incision is made.

Generally, for those procedures where a splinter or other foreign body is removed, a physician would report only the appropriate E/M service, unless the procedure was so complicated as to warrant an unlisted procedure code. In the event that unlisted code 17999 is used, office notes with a detailed description of what was done should be included with any claim for reimbursement.

If exploration of the wound was required in a more complicated case of foreign body removal, it might be appropriate to use the CPT code range 20100-20103. CPT Assistant includes some clinical examples.[1] The examples describe procedures involving use of an operating room rather than a physician's office or urgent care setting.

Question: Some health plans are telling us that when immunization services are provided in conjunction with preventive care service codes 99381-99397, we may not report the CPT codes for their administration. Are there any official coding guidelines that may be used to defend our coding?

Answer: The coding guidelines are clearly outlined in the *CPT Manual.* The last paragraph following the preventive medicine category states, "Immunizations and ancillary studies involving laboratory, radiology, or other procedure are reported separately."[2] The vaccine and toxoid codes were revised significantly in 1999 so that the vaccine is now separately coded from the administration. So from a CPT standpoint, two codes are always required to fully report immune globulin and vaccine/toxoid administration.

CPT also advises that "If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes."[3]

Health insurance carriers may have reimbursement or payment polices stating that they do not pay extra for injection administration in conjunction with any other office service. Continuing to bill for and report noncovered services may create contractual problems and create dissatisfied patients. It may be helpful to educate the involved health plans concerning the CPT guidelines and hope for future change in policy that does not require you to misrepresent actual patient services rendered. This gets tricky since the patient would normally pay for a service that is not covered. If the health plan says that the administration of the vaccine is included in the payment for the E/M service, the office may not be allowed by participation agreement to bill the patient.

Modifier -25 should always be used on insurance claims when a significant and separately identified E/M service occurs. For the insurance company's benefit—and to explain the extra charges to the patient—the documentation within the record should clearly show the physician history, examination, and medical decision making that constitute the separate reporting of E/M codes. It is never appropriate to add on a visit code just because the patient came to the office for another service, such as an immunization. However, it is always appropriate to code all services provided in accordance with CPT guidelines.

Notes

1. American Medical Association. *CPT Assistant* 6, no. 6 (1996): 7-8.

2. American Medical Association. *Current Procedural Terminology.* Chicago, IL: 1999, 33, 376.

3. *Ibid.*

References

American Hospital Association. *Coding Clinic* 9, no. 3 (1992).

American Medical Association. *CPT Assistant* 9, no. 5 (1999).

American Medical Association. *Current Procedural Terminology.* Chicago, IL: 1999.

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Article citation:
Scichilone, Rita, and Ann Zeisset. "Back to Basics: Coding for Physician Services." *Journal of AHIMA* 70, no.10 (1999): 65-66.

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