**Coding Level-One Office Visits Webinar 3/31/16**

**Question & Answers**

**Question #1:** If a PA is doing STI counseling and follow-up risk reduction plan, but there is not enough to bill for E/M 99211, can a 99211 be billed?

**Answer:** Yes. Physicians and mid-level providers (Nurse Practitioners and Physician Assistants) can bill for a 99211, although CPT’s intent with the code is to provide a mechanism to report services rendered by other individuals in the practice (such as a nurse or medical assistant).

**Question #2:** Each example mentions consulting with a qualified provider when patient is there. Is that required to bill 99211?

**Answer:** The physician does not have to be in the room, but the supervising physician has to be on the premises (e.g., in the office suite) and he/she must be immediately available to assist the non-physician provider rendering the service if needed.

**Question #3:** In our teen health center our RN’s have to find out when their last period was and possibly do a pregnancy test before providing vaccines. The patient’s height, weight, vitals and temps are taken, allergy history, etc.If a NP does an immunizations only visit, what do you bill for?

**Answer:** The vaccine administration fees cover the patient’s health history and vitals so you would only bill for the vaccine administration fees and vaccines codes. It would also be appropriate to bill for the pregnancy test, if performed in the office.

**Question #4:** How are RN’s not considered capable of counseling on Imms? This is common practice in Local Health Departments

**Answer:** According to the CPT manual, 90460-90461 counseling codes should only be reported when the physician or qualified health care professional provides face-to-face counseling of the patient/family during the administration of a vaccine.

Qualified healthcare professionals are separate from “clinical staff.” Typically, clinical staff is defined as someone working under the supervision of the physician or other qualified health professional. Most health centers obtain separate billing NPI numbers for their nursing staff, therefore, they are working under the “supervision” of the physician or other qualified health professional.

**Question 5:** How does 99211 come in to play with Telehealth billing?

**Answer:** Although I have not been able to find any specific information regarding Telehealth billing for nurses, I can tell you that CPT 99211 may be used only for face-to-face encounters. Telephone encounters are not billable using this code.

**Question #6:** If a Social Worker is billing for a counseling “Incident to,” when documenting the clinical reason, does that need to be a physical health clinical reason (e.g., if someone is obese)?

**Answer:** If you are providing counseling services in follow-up to a medical provider’s request, I believe you would want to document the primary medical diagnosis (e.g., obesity). Professional services for Licensed Medical Social Workers are typically billed out under the social worker’s individual NPI so this would not necessarily qualify as an “incident to” service. You can still bill a 99211, but there may be a more appropriate evaluation and management code to choose from.

**Question #7:** If the NP does an immunization only visit what do you bill for?

**Answer:** You would only bill for the vaccine administration and vaccine biologic only.

**Question #8: What is an E/M code?**

**Answer:** Evaluation and Management

**Question #9:** What does it mean when you say add a modifier?

**Answer:** Modifier 25 is used to describe a “significant and separately identifiable” evaluation and management service by the same provider on the same day of the procedure or other service.

For example, if immunizations are provided in conjunction with a medical office visit (99202-99205, 99212-99215, 99381-99386 or 99391-99396) you would want to include a modifier “25” on the E/M code.

If a provider bills for a 99213 – Level III Est Pt Office Visit, as well as a 97802 – Medical Nutrition Counseling, but the only diagnosis provided is for Overweight (E66.3), a modifier “25” would not be appropriate as the documentation would like not support a significant and separately identifiable service.

**Question #10:** There seems to be a different view point between the CMS guidelines and Michigan Medicaid when it comes to CPT Code 99211. CMS refers to these visits as an “Incident to”, but Michigan Medicaid refers to them as “Physician Delegation and Supervision.” In the Medicaid Manual, Practitioner Chapter 1.7, it does not require the “physician” to be physically present. This is creating some confusion as to who has to be in the office.

**Answer:** A Physician/Other Qualified Health Care Professional (e.g., Nurse Practitioner or Physician’s Assistant) need only be present in the medical office suite at the time services are provided.

**Question #11: If a Social Worker bills for a 96127 - Brief emotional assessment/GAP assessment, and then sees the patient later in the same day for a 90837 – Psychotherapy visit, what modifiers would you use to ensure that both visits are covered.**

**Answer:** Most payers will not pay for two visits with the same medical provider on the same date of service regardless of whether or not a modifier is attached.