BIG CHANGES IN 2021 CPT FAQ

How is it possible that they pay us LESS than they already do? And also take away the ability to bill for work done prior to/after the actual date of service?! Sigh.

Just what they can do when the insurance company is in control! So so sorry.

Can you bill a 99214 for acute otitis media if you use fever as a systemic symptom?

IF you believe that fever is a systemic symptom, then yes, however, according to the AAP, symptoms such as fever, body aches and fatigue that you will treat to help them feel better in general would NOT be systemic symptoms.

Otitis media with irritability?

I would think that could be systemic symptoms, again, kind of vague on what systemic symptoms really are according to AAP.

Wouldn't an OM with fever in a young child/infant lead to consideration for sepsis or other infection?

Again, just going by the AAP site they are stating "general symptoms" are not systemic. My thoughts are that IF you feel that these symptoms are systemic, then list all of them and it would be moderate problems.

In what way will this ever improve patient care?

The idea is that you will NOT sit and think that you have to have specific criteria for the history and exam-that those pieces will be dependent on what the presenting problems are and what you need to do to treat the patient. Means your history and exam could literally be a couple sentences long. As you get use to this new concept of leveling your care, I do believe it will allow you to spend more time in patient care. Call me an internal optimist.

Would this include a weight check for an obese patient who has gained weight/BMI?

That would qualify for a chronic problem with progression I would think.

Febrile seizure: where can that fit?

I would think that would fit the undiagnosed new problem with unknown prognosis-you are going to assume it is a febrile seizure BUT will be watching closely and maybe even refer to Neuro for further work up.

Can you include in that ADHD patient "consulting with another historian?" Who might be parent OR teacher? What if we're reviewing requested records from the teacher?

If you are talking with the teacher, that would count in the data category #3, talking with parent would be data-historian. If you are reviewing records from the teacher-that would be review of external notes in data -category #1.

Please about overweight patient who has gained weight... Progression? They are coming in for the weight check. Since we see adolescents alone, at what age does the parent become an additional historian?

Yes, would assume if chronic it would be with progression with a weight gain. As for the historian, if you need to have the parent add to the history (confirmation) then they would count as historian.

If I make referral (typed hx), can that be consider external communication or it has to be verbal?

In order for it to count for data as in category #3, it has to be verbal or even through email but has to be a discussion, not just a referral note.

With a new patient if you hear a murmur and ask the parent if they have been diagnosed with a murmur and they said not sure (say "it's dad" and he has no clue) so then you review the notes from the last PMD to see if the child was diagnosed with a murmur or not does that count?

They are the same specialty so I'm guessing no. (And say it is a benign murmur so no cardiology consult notes in chart).

IF the peds doctor IS NOT in your group but the patient is transferring to you and you review the notes, then yes it would count. Benign murmur when you are not going to do any type of treatment would more than likely be an acute uncomplicated illness.

We're now being told that we have to bill only what's done on the DATE of the visit. What if we talk to the teacher another day? Or review the prior medical records thoroughly the day before the visit? How are we going to be paid for these services?

You can always bill the 99358-30-74 min. of prolonged non-face to face time. For services spent reviewing records, discussing the patient with other appropriate sources (not family, parents etc), then you can bill the 99358 if you have at least 30 min. Now, do this ONLY if not on the same date as the encounter.

So, no labs done in office would count? Like a srep test, flu test, UA, Hgb? Guess they would go into more complicated MDM

All labs, services etc ordered and not performed in the office can be counted in the data piece of the MDM. IE: you order strep culture, covid test outside of the office and historian, you would have met category #1 of moderate data.

So, if each unique test counts, should I order liver panel and renal panel instead of Basic metabolic panel?! This seems rife with potential issues. And a separate glucose?! Every overweight patient would have "high" risk- for heart disease, diabetes, SCFE, etc. Does Rx for exercise or diet modification count?

Any lab that has a specific cpt code that includes other panels should be what is ordered and you do not ‘unbundle’ them. For example, order a CBC instead of a hgb, hct, plateslets as individual test.

So, is the risk level moderate any time we prescribe something (non-OTC)?

That would fit the criteria for moderate risk-RX has to be a new rx or on-going rx management for a chronic condition.

If we order strep culture is it considered ordering and interpreting as 2 units or one unit?

If you order a strep culture, it is only one unit-the cpt code doesn’t have a separate code for doing an interp and review.

How about diagnosing a nursemaid's elbow?

24640 has a 10 day global period, so it would be a decision to do minor surgery which meets the moderate risk. This, unfortunately, would not be a complicated injury as you are not referring them out for further treatment. SO, unless you have data in the moderate range, the visit is going to be a 99213-25 and the 24640.

If reviewing newborn hospital records and review the bilirubin value in the records, does this count as 2 data reviewed? Or one?

If you are reviewing the record and the bili is in the record, it would only count as one piece reviewed.

What if it's a rapid strep (comes back neg) and reflex culture? I collect the specimen but send out both tests to lab.

If it is two separate tests ordered, then you would have two pieces for data in category #1.

Do you need to add a modifier when billing a prolonged service on the same date of service?

No modifier, it is added to the 99205-99215. If you modify anything it would be the visit code only with a 25 IF you have other services other than the prolonged care.

What about 'interpreting' a bone age. The radiologist reads it, but we interpret what it means to the patient. Can we count that at all for data?

As long as you are not billing for the interp or the bone age, then it would count as review of test for data.

RE: the data count of "ordering a unique test" - are you saying that ordering a test that I do in-house does NOT count towards this one? Only if I send them to a lab? I understand that REVIEWING that in-house lab doesn't count...

Yes, unfortunately at this time BUT I am thinking this is going to change in the future, but that's just me.

High fever associated with otitis media; would we also consider systemic illness like sepsis?

If you believe it is NOT just a general symptom, then yes.

If we have patients bring in their peak flow record for the asthma f/u, is that a valid "data" unit?

They indicate it is external provider and not parent so am thinking the answer would be no.

If Vanderbilt f/u survey is done at ADHD follow up visit, will that meet the criteria of independent interpretation of test?

No, only because when you get them back and do your interp on them, you will be billing the 92167 and if you are billing for them, they cannot count in the MDM piece.

What about a patient with exposure to COVID-19 with symptoms, did swab in office, sent to lab, discussed discharge instructions, called them daily to follow up and discussed COVID results positive, reported to public health level 4 or 5?

I could see that this would be an undiagnosed new problem with uncertain prognosis so moderate problem-if you consider them to be extremely ill that they have a threat to their life, then high problem BUT I would say it could be a 4 or 5 if based on time. Remember track the time before seeing the patient, visit itself and then after on the same date of service. You cannot charge for the other times not on the same date. Obviously if you admit them, then it is a 99205/99215.

Is "living through COVID-19 pandemic & shut down" a valid chronic condition?

I wish it was!! But no. There is NO ICD-10 for this dx.

Can you give more examples of what the 99358 can be billed with? Oh, it's a stand-alone code? But the 99354 is going away, right?

Yes, the 99354 goes away. So let's say you have an extreme preemie coming in and you review all of infants notes the day or two prior to seeing the infant. IF you do this and spend >30 minutes, then you will bill the 99358 under the baby's name and ID.

Can we bill based on time when billing a well exam plus office visit?

Yes, so basically you will want to state "spent an additional 10 minutes in a discussion concerning increasing their medication" so that would be a 99212 visit in addition to the well care visit.

So how do we submit prolonged care code done after the visit if code already submitted on DOS?

The prolonged care code non face to face is a separate billing. If you are saying the new 99417 after you have billed the 99205/99215-then you will want to refile your claim.

If we have a patient hospitalized and they are being managed by a hospitalist, but we go visit them and discuss their care and answer questions and review the chart, can we use the 99358?

NO, you can bill a subsequent hosp. care day ONLY if you are writing a note in the chart and are participating in their care (orders etc).

What if we're writing notes in the chart and providing continuity of care? I mean, in our own office chart?

NO, just doing good patient care.

Is elevated BMI/obesity addressed during a well check with labs ordered and other counseling coded as an additional sick visit?

It certainly could be if it is significant! Base it on MDM only, add some history no exam.

We started using scribes at our office to help with charting time. Can the scribes' charting time be added to the total time of the visit?

As long as they are documenting what you are doing and YOUR time only, sure. Be certain to add your attestation that the information was review by you and you agree with all that was documented.