February 21 Webinar Q&A
Answers provided by Terry Fletcher

What is the time period when you can bill for an initial office visit when you have seen the patient in the past?
As stated on slide 6, and on page 4 of your 2024 CPT book, it is 3 years, from anyone from your group same specialty or subspecialty

Would you comment on physicians who make house calls, and any particulars that apply for billing or any anticipated changes in billing?
"CPT has revised codes for at-home evaluation and management (E/M) services as of Jan. 1, 2023. Services to patients in a private residence (e.g., house or apartment) or temporary lodgings (e.g., hotel or shelter) are now combined with services in facilities where only minimal health care is provided (e.g., independent or assisted living) in these code families: (check on your POS' which could be 04, 12, 13, 14 etc - inside first page CPT)
Home or residence E/M services, new patient
• 99341, straightforward medical decision making (MDM) or at least 15 minutes total time,
• 99342, low level MDM or at least 30 minutes total time,
• 99344 (code 99343 has been deleted), moderate level MDM or at least 60 minutes total time,
• 99345, high level MDM or at least 75 minutes total time.
Home or residence services, established patient
• 99347, straightforward MDM or at least 20 minutes total time,
• 99348, low level MDM or at least 30 minutes total time,
• 99349, moderate level MDM or at least 40 minutes total time,
• 99350, high level MDM or at least 60 minutes total time. "

On annual H and P in a nursing home, please define G0438 vs. G 0439 on initial vs. Subsequent.
Medicare issued updated guidance to AWV's. Here is the link. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

What if a pt sees Gastroenterologist in the same office as an Internal Medicine physician in the same office - can both these visits be new patient visits? One is GI and one is IM e.g pt got a colonoscopy w GI MD then establishes care w IM doctor (same office same Tax ID but different subspecialty)
This is a cross over specialty. GI/Int Med. Yes, there are 2 specialties, but remember on the same date is the issue. Also "establishing care" is not an E/M it is preventative.

Do they now require time to be documented in the visit note? instead of going off of just MDM?
No. You can use either time or MDM as stated on slide 5 of the PPT

If we are using Medical Students can we use their time with the patient?
On slides 12, 13, 14 time of the billing provider is the ONLY time that can be considered if you are using time to level your visit. No time of any other staff can be used

I thought there was a e/m code for consultation with family where the patient wouldnt be present

As of 2021, the new guidelines, there is not. As I mentioned in the Webinar, you can always charge a cash price to the patient for a non-patient visit. Use unlisted 99499 to post it on the patient's' ledger. This is not an insurance billable service.

How do we account for "patient present" if the patient has dementia or is in a facility and is bed/home bound and is unable to participate in the encounter?
The patient has to be face-to-face and present during the encounter. If the visit is only with caregivers or family then that is a cash patient encounter. New 2021 rules

Does the prolonged care code also apply to non-face-to-face care by the physician or only face-to-face care on the day of the visit?
Prolonged care is only added to a level 5 that has met their time threshold, and it has to be FTF as stated in CPT

Could you please clarify if the time providers spend on after-hour documentation, such as reviewing records and placing orders post-visit, should be included in the overall time calculation for our E/M services? We've noticed that these tasks often require considerable effort and thought, and we want to ensure that our billing accurately reflects the time and effort invested in patient care. Your guidance on this matter would be greatly appreciated.
Yes, they can use the time they chart and do their own work on the individual patient after hours. But remember most orders placed are done by staff. Also, if any history or exam elements were done by staff that cannot be counted. Also keep in mind that any testing that was separately billed for cannot be included in the time. Re-read the slides on time 12-15 in the PPT

If the test is ordered on day 1 in the hospital and reviewed on day 2 (by the same provider) can they get 1 credit for each day?
No. Slide 25 addresses that CPT is clear that the "..ordering of a test is included in the category of test result(s)...." page 8 under 2nd bullet CPT 2024

If we review all the patient's medications for say 3 conditions and then either make adjustments to refill them does that automatically make it a level IV?
That is one element in risk for a level 4. There are 2/3 elements needed to reach a moderate level of service

Are there any Telehealth codes you can safely bill for Telehealth for a severely demented patient who cannot participate?
Not that I am aware of

What if you order tests at a preventative code and ONLY code for that preventative code and then bring back to go over the labs that are for a problem. I was told by certified biller that you CAN bill for a problem visit to go over and state "not previously billed"
Labs that are routine from a preventative are not allowed to be double dipped in Data Points at a subsequent visit. Page 8 CPT

I provide 1/2 hour visits and am able to cover most everything. Can you clarify when and how I can bill E/M + preventive + medicare annual or the combination that WOULD work?
You can ONLY report a preventative visit with an E/M if during the preventative visit, "..an abnormality is encountered...and if the problem or abnormality is significant enough to require

additional work to perform the key components of a pro-oriented E/M..." So you cannot have a patient scheduled for an OV and then do a preventative. Page 35 CPT. Same with the AWV.

How many times a year can you bill G2211 for same patient?
There are no frequency guidelines yet. CMS is said to be updating their guidance soon.

So can we elaborate more on the requirements for billing code G2211
We can only give you the most recent published guidance from CMS. MLM 13473 is the most recent guidance. Also found on slide 39 as discussed

What about text communication?
That has to be provider to provider related to a visit, and incorporated into the documented note. It also has to be a secure device that the tests are exchanged from.

For split/shared visits, does the physician need to document 2/3 for MDM if he/she is billing? Even if the NP documented. 2/3?
Slides 53-54 address the split shared visits updates for 2024

If we do a mastectomy , patient returns a few days after. positive margins, needs surgery again, and discussion re radiation or chemo, is there an E/M code we can use or is it global?
That is global

I am a pediatric hospitalist, and I work at a community hospital. If I admit a patient to the community hospital, and then during that stay, have to transfer the patient to the regional children's hospital, is that considered part of the same admission/stay?
If this is a different facility it is not the same stay for the intake physician at hosp 2. But if you continue to follow that patient , you can only report subsequent hospital visits, per CPT p. 18. Also slide 51 in the PPT

Please clarify. If a patient refers to a specialist in the hospital Specialist ,Specialists cannot bill 99221-99223?
If a physician refers a patient to a specialist outside of their practice, different specialty, then it is appropriate to report 99221-99223.

md sees patient in er who is admitted. we use admission code but mostly denied as too many services on same day. that is other providers entered same code. different specialty. what code or should we use AI?
When the MD sees the patient and then admits a patient in in-patient, that is 99221-99223 and for Medicare the modifier is -AI for admit inpatient. There should not be an ER visit as well, as it is where they land. The CPT book infers you can bill both but Medicare and payers state you cannot. If another specialty then sees the patient, during the same stay, that is not part of your practice, then that is also a 99221-99223 no modifier different diagnosis. If the subsequent physicians have seen the patient prior to this stay as a pre-op or during the stay from the same practice then they have to use 99231-99233 for their initial encounters.

What is the modifier for billing for 99441-99443 audio-only visit? Thanks.
There is no modifier needed on audio only visits. The POS is not 10

Have additional questions? The Coding Corner Network Membership is an online Q&A coding assistance service for “members only” offered by Terry Fletcher Consulting, Inc. Learn more: https://www.terryfletcher.net/services/coding-corner-network-membership/