Primary Care Billing- Do's and Don'ts

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3 Important topics to cover:

- **Vaccines** coding:
  - ✓ Influenza, Pneumococcal and Hepatitis B vaccines
- **Annual Wellness Exams vs Preventive annual visits**
- **Transitional Care** coding

Seasonal Influenza Virus Vaccine codes:

90630 – Influenza split virus vaccine, quadrivalent, preservative free, for intradermal use

90653 – Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use

90654 – Influenza virus vaccine, split virus, preservative-free, for intradermal use

90655 – Influenza virus vaccine, trivalent, split virus, preservative free, when administered to children 6–35 months of age, for intramuscular use

90656 – Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use

90657 – Influenza virus vaccine, trivalent, split virus, when administered to children 6–35 months of age, for intramuscular use

90660 – Influenza virus vaccine, live, for intranasal use

90661 – Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use

90662 – Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use

90672 – Influenza virus vaccine, quadrivalent, live, for intranasal use

90673 – Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use

Seasonal Influenza Virus Vaccine codes:

90685 – Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6–35 months of age, for intramuscular use

90686 – Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use

90687 – Influenza virus vaccine, quadrivalent, split virus, when administered to children 6–35 months of age, for intramuscular use

90688 – Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use

Q2035 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)

Q2036 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)

Q2037 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)

Q2038 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)

Q2039 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)

Seasonal Influenza Virus Vaccines for Medicare:

- **Administration Code:**

  G0008

- **Diagnosis Code:**

  Z23

- **Frequency:**

  Once per influenza season

Seasonal Influenza Vaccines Pricing Link- cms.gov

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html

Pneumococcal Vaccine Codes:

90670 – Pneumococcal conjugate vaccine, 13-valent, for intramuscular use

90732 – Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use

Pneumococcal Vaccines for Medicare:

- **Administration Code:**

  G0009

- **Diagnosis Code:**

  Z23

- **Frequency:**

An initial pneumococcal vaccine to Medicare beneficiaries who have never received the vaccine under Medicare Part B; and A different, second pneumococcal vaccine 1 year after the first vaccine was administered

Hepatitis B Vaccines:

90739 – Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use

90740 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use

90743 – Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use

90744 – Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use

90746 – Hepatitis B vaccine, adult dosage (3 dose schedule), for intramuscular use

90747 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use

Hepatitis B Vaccines for Medicare:

- **Administration Code:**

  G0010

- **Diagnosis Code:**

  Z23

- **Frequency:**

  Scheduled Doses Required

Frequently Asked Questions:

If a beneficiary gets a seasonal influenza virus vaccine more than once in a 12-month period, will Medicare still pay for it?

- Yes, Medicare pays for one seasonal influenza virus vaccination per influenza season; however, a beneficiary could get the seasonal influenza virus vaccine twice in a calendar year for two different influenza seasons, and Medicare would pay the provider for each.

Will Medicare pay for the pneumococcal vaccination if a beneficiary is uncertain of his or her vaccination history?

- Yes, if a beneficiary is uncertain about his or her vaccination history, provide the vaccine and Medicare will cover the revaccination.

Does Medicare cover the hepatitis B vaccine for all Medicare beneficiaries?

- No, Medicare covers the hepatitis B vaccine for certain beneficiaries who are at intermediate to high risk for the hepatitis B virus (HBV). These individuals include health care professionals who have frequent contact with blood or blood-derived body fluids during routine work, those with End-Stage Renal Disease (ESRD), persons who live in the same household as an HBV carrier, and persons diagnosed with diabetes mellitus. Other situations could qualify a beneficiary as being at intermediate or high risk of contracting HBV.

Frequently Asked Questions:

When a beneficiary gets both the seasonal influenza virus and pneumococcal vaccines on the same visit, do I continue to report separate administration codes for each type of vaccine?

- Yes, see *https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html* for individual Change Requests (CRs) and coding translations for ICD-10. Use separate administration codes for the seasonal influenza virus (G0008) and pneumococcal (G0009) vaccines. **Medicare pays both administration fees if a beneficiary gets both the seasonal influenza virus and the pneumococcal vaccines on the same day.**

Can providers bill both the vaccines and the E&M codes on the same day?

- Yes. If the E&M code was related to a separately identified service. Both can be billed on the same day.

Administration Codes for Commercial Insurance Plans:

90471- Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)

90472- Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure.

90473- Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid).

90474- Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).

Coding for Medicare Initial Preventive Physical Examination (IPPE):

Billing Codes:

G0402- Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.

G0403- Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report.

G0404- Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination.

G0405- Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination.

Diagnosis:

Z00.00- Encounter for general adult medical examination without abnormal findings

Z00.01- Encounter for general adult medical examination with abnormal findings. Use additional codes to identify abnormal findings.

Frequency:

All new Medicare beneficiaries who are within the first 12 months of their first Medicare Part B coverage period may get an IPPE. This is a one-time benefit.

The ABCs of the Initial Preventive Physical Examination (IPPE) Medicare Learning Network

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

Coding for Medicare Annual Wellness Visit:

Billing codes:

G0438- Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit.

G0439- Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit.

Diagnosis:

Z00.00- Encounter for general adult medical examination without abnormal findings

Z00.01- Encounter for general adult medical examination with abnormal findings. Use additional codes to identify abnormal findings.

Frequency:

Medicare pays for only one first AWV per beneficiary per lifetime and pays for one subsequent AWV per year thereafter.

Frequently Asked Questions:

Is the AWV the same as a beneficiary's yearly physical?

- No. The AWV is not a "routine physical checkup" that some seniors may get every year or so from their physician or other qualified non-physician practitioner. Medicare does not cover routine physical examinations.

Are clinical laboratory tests part of the AWV?

- No. The AWV does not include any clinical laboratory tests, but you may make referrals for such tests as part of the AWV, if appropriate.

Do deductible or coinsurance/copayment apply for the AWV?

- No. Medicare waives both the coinsurance or copayment and the Medicare Part B deductible for the AWV.

Can I bill an electrocardiogram (EKG) and the AWV on the same date of service?

- Generally, you may provide other medically necessary services on the same date of service as an AWV. The deductible and coinsurance/copayment apply for these other medically necessary services.

The ABCs of the Annual Wellness Visit- Medicare Learning Network

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

Billing Commercial Payers for Preventive Annual Visits:

Billing Codes for Initial Preventive Visit:

99384- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent *(age 12 through 17 years)*.

99385- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; *18-39 years*.

99386- Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; *40-64 years*.

99387-Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; *65 years and older*

Diagnosis:

Z00.00- Encounter for general adult medical examination without abnormal findings

Z00.01- Encounter for general adult medical examination with abnormal findings. Use additional codes to identify abnormal findings.

Frequency:

Only bill once for a new patient in the practice.

Billing Commercial Payers for Preventive Annual Visits:

Billing Codes for Subsequent Preventive Visit:

99394- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent *(age 12 through 17 years)*

99395- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; *18-39 years*.

99396- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; *40-64 years*.

99397- Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; *65 years and older*

Diagnosis:

Z00.00- Encounter for general adult medical examination without abnormal findings

Z00.01- Encounter for general adult medical examination with abnormal findings. Use additional codes to identify abnormal findings.

Frequency:

Standard timeframe is every 12 months. Please double check the guidelines for each individual patient's plan.

Transitional Care Management Services:

The requirements for TCM services include:

- The services are required during the beneficiary's transition to the community setting following particular kinds of discharges.
- The health care professional accepts care of the beneficiary post-discharge from the facility setting without a gap.
- The health care professional takes responsibility for the beneficiary's care.
- The beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making.
- *The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days.*

Transitional Care Management Services:

TCM COMPONENTS:

During the 30 days beginning on the date the beneficiary is discharged from a hospital inpatient setting, you must furnish the following three TCM components:

- **An interactive contact:** You must make an interactive contact with the beneficiary and/or caregiver, as appropriate, within 2 business days following the beneficiary's discharge to the community setting. The contact may be via telephone, email, or face-to-face.
- **Certain non-face-to-face services**: You must furnish non-face-to-face services to the beneficiary, unless you determine that they are not medically indicated or needed.
- **A face-to-face visit**: You must furnish one face-to-face visit within certain timeframes as described by the following two Current Procedural Terminology (CPT) codes:

99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)

99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)

Transitional Care Management Services- Medicare Learning Network Link:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

Questions

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