Coding & Documentation

CME

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AMBULATORY BLOOD PRESSURE MONITORING DATE OF SERVICE

Q What date of service should I report for a patient who has completed ambulatory blood pressure monitoring for 24 hours or longer after I have reviewed and interpreted the data (CPT code 93784)?

A Use the date that you interpret the data and create your report, because that is when the service is complete. When you are reporting the complete service (technical and professional components), both the monitoring time required in the code descriptor and the interpretation and report should be completed before billing. If you are reporting only technical components (recording or scanning analysis with report), the date of service is the date the monitoring concludes based on the time in the code descriptor.

METERED-DOSE INHALERS

Q Our practice wants to begin treating respiratory symptoms in established patients using their own metered-dose inhalers (MDI) instead of nebulizers to avoid generating aerosols. What codes could we use to receive payment for these services?

A Report inhalation treatment with an MDI with the same CPT code you would use for treatment with a nebulizer: 94640, "Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler, or intermittent positive pressure breathing (IPPB) device." However, your practice would not report a charge for medications used in this case because the patient supplies them.

RETINAL IMAGING SCREENING FOR DIABETIC RETINOPATHY

Q What codes should we report for digital retinal imaging to screen for diabetic retinopathy when we capture images in the family medicine clinic and digitally transmit them to an ophthalmology center, which interprets the images and returns a report to us?

A Report code 92227, "Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral." If you are participating in a quality reporting program, you may also use a Category II quality measurement code from 2022F-2033F to indicate the screening was performed and whether retinopathy was found.

ATTENTION-DEFICIT HYPERACTIVITY DISORDER PRESCRIPTION MANAGEMENT

Q What code do I bill for prescription drug management when I see patients in the office with previously diagnosed attention-deficit hyperactivity disorder (ADHD) and renew or revise their prescriptions?

A Following the E/M guideline changes of 2021, when you provide ongoing management of a chronic condition such as ADHD, you should report an established patient office E/M service code (99212-99215) based on the medical decision making (MDM) necessary to manage the condition during that visit, including prescription drug management. Chronic illnesses without severe exacerbation or progression are typically level-3 or level-4 problems depending on how many there are and how stable they are. Deciding to continue the same medication and same dose is considered prescription drug management, which is level-4 risk.

As an alternative to coding based on MDM, you can code the visit based on your total time spent on the date of the encounter, regardless of whether that time was spent face-to-face or in counseling and/or coordination of care.

CONGENITAL HEART DISEASE IN ADULT PATIENTS

Q Is it appropriate to report an ICD-10 code for congenital heart disease in an adult patient?

A Yes, if the condition has not been fully repaired, report an ICD-10 code for it (probably one from Q20 through Q26.9, depending on the nature of the heart condition). Congenital heart defects may be partially repaired or even go undiagnosed until adulthood. They should be reported when the condition is evaluated or managed, or when it affects the management of other conditions. However, if the condition was fully repaired, report Z87.74, "Personal history of (corrected) congenital malformations of heart and circulatory system," not a code for the prior condition. FPM

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Cindy Hughes is an independent consulting editor based in El Dorado, Kan., and a contributing editor to *FPM*. Author disclosure: no relevant financial relationships.

EDITOR'S NOTE

Reviewed by the *FPM* Coding & Documentation Review Panel. Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

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