Sports and School Physicals - Code Them for What They Are

Information vital to charging a preventive code for student physical visits is outlined in-depth along with specific summertime coding issues.

By Douglas J. Jorgensen, DO, CPC

Every summer, your healthy adolescent population trickles through your office, increasing to a near frenzy by summer’s end. Many parents plan ahead and schedule an appointment so Jennifer can play soccer or Mike can go out for the football team. Other parents take care of this task before school is out to get medical clearance for summer camps or recreation programs.

However, there will be more than a few parents calling you at the eleventh hour to get your signature so their child can go to camp or start with the team for preseason training. Often these visits are quick and subsequently they get a low-level established office visit code of 99212 or 99213.

However, this is a problem, for what you actually provided was a preventive service, and as such, that is what you should charge.

The purpose of this article is not to review hernias or concussion evaluations to determine who can or cannot participate in a given event or sport. Rather this article will outline what should be included in these visits to charge a preventive code and why this is needed, as well as addressing the issue of preprinted, school based forms that are often medically inadequate and, from a coding documentation perspective, virtually useless.

To begin, why not charge an acute visit since its quick and you really just reviewed the chart and did a brief exam? Hopefully, if you are releasing an athlete to participate, your exam was more thorough than a quick follow-up for a URI or otitis media. However, sometimes these visits are approached just as quickly and with no concern for the proper code. Lastly, we will address how to handle an acute issue seen concomitantly with the sports/camp physical using the –25 Modifier.

Why Not an Acute Visit or Established Patient Code?

These codes (99381-99387)² are intended to be used to care for a problem that creates medical necessity for the patient to be in your office.

By definition, a screening exam to approve or deny your patient from participating in a given activity is not addressing an acute event, particularly if he or she is healthy. If the patient has an acute issue, use the –25 Modifier on an E&M code in addition to the preventive medicine codes.³ We will go over this further below.

Most of your school or sport physicals have little to no acute medical issues that need addressing. Therefore, the service you are actually providing is the same as a well child visit or an adult yearly preventive medicine examination. To charge for an acute visit because it is easier or because you want to help get the visit covered is, in short, fraud.

Therefore, establish some guidelines in your compliance plan for your practice that sports, camp and/or school physicals will be coded and documented as a preventive medical service. The last step is to follow this rule.

Elements Required for Preventive Medicine Visits

History⁴ These visits are designed to detect issues that are potentially dangerous or could make participation in the activity for which they are being done a hazard or injurious to the patient at hand. Thus, in most cases there will be no complaint, just a healthy patient awaiting your blessing to begin his or her sport/activity of choice.

Therefore, you do not need a History of Present Illness (HPI) since there is no illness to describe. Instead state in your chief complaint or c/o section: “Here for school sports physical.” You do need to have a Review of Systems (ROS) and 10 of the 14 areas must be covered.

If you do not get 10 ROSs you cannot charge for a preventive visit and if audited you cannot be down coded (i.e.: 99214 to 99213), as the preventive codes are a yes/no question in an audit situation. Either you had all the required information or you did not. If the latter is true, you must return payment for the entire visit if it is discovered.

The ROS issue of needing 10 areas is the single largest problem in the thousands of chart audits we have done. This is the primary culprit in codes billed being listed as a no code possible due to insufficient documentation.

Even if all the areas are negative, they need to be addressed in writing. You can write “Eyes: Negative, Lymph: Negative.” However, writing “ROS: All negative” will leave you suspect in the event of an audit. Make your documentation unambiguous and list all the systems, as all are important and germane in a preventive visit scenario.

In addition to the ROS, you need a PFSH (past family, medical, social and medical histories.) You can reference the PFSH to your medical record if nothing new has happened by writing “see pink sheet” or “PFSH section” if you list your information on family, social histories and personal medical histories in one area of the chart.

You could even reference an acute visit note where these areas were thoroughly reviewed by dictating “see PFSH from 2/13/02.” If you think these areas are not germane you can write NC or noncontributory.

However, you must at least reference them or put NC to get credit for having addressed them as the history for all preventive visits must be comprehensive per CPT and the federal documentation guidelines.

Physical Examination⁵ The physical exam is the easiest part of your documentation. Once again, we recommend you use the 1995 exam and you can get the required comprehensive examination by doing an eight-body area/organ system examination.

Although, the 1995 exam allows for a complete single system exam (using the 1997 guidelines definition of a complete single system exam is recommended when this rule is utilized), preventive visits require a multisystem exam. Thus, without two eight area/systems examined and documented, you did not have enough areas to charge for the preventive visit code.

The 1995 system allows for a Constitutional exam to be WDWM in NAD or a lung exam to be CTA. This would not be allowed in the 1997 guidelines and this is really outside the scope of this article to pursue further.

In short, do at least eight areas or systems for school/sports physicals and you will more than cover the required...
elements and medically perform a rather thorough exam.

Medical Decision Making
In a preventive exam, anticipatory guidance and screening are part of the exam. Some groups want blood work or urinalysis and without a diagnosis, you are doing these for screening purposes. Sometime insurers/payors will cover these, sometimes they will not.

If you send out a specimen (i.e.: urinalysis), you can only charge for the handling (99000 code.) However, if you do phlebotomy (CPT code 36415*) it should be charged for all blood draws. This is a started procedure so no pre or post procedure services are implied or bundled as part of this code.

However, do not charge the 99000 and the 36415 code for a blood draw alone; only use 36415*. If you do a urine and a blood draw then these codes can be used simultaneously for their respective tests. Beyond screening lab work, the only real medical decision you are making in these cases is whether or not the patient can play the sport.

If you are making anticipatory recommendations, then it is part of the fee for the preventive visit (i.e.: advising having an ankle taped if the patient sprains it.) However, if you have found the on the visit or that the patient complained about at the time of the visit.

The ICD-9 or diagnosis codes for the acute issues justifies the E&M service with the −25 modifier. These too need to be in your dictation as well as on your encounter form or super bill.

Many providers give acute care with preventive codes and do not code for them thinking it is part of the service or they do not think the insurer will likely pay. However, you should be paid for the work you do. Therefore, submit these codes and be willing to fight for them if they are initially denied. If denied, your documentation will likely be requested.

It is recommended that you have two notes, one that is the preventive visit and the other for the acute visit. Since many of these patients have their own forms, you really are dictating or writing only one note. Make the effort and in the long run, the acute visits will accumulate and you will reap the benefits of working smarter in these situations.

School/Camp Forms
When patients bring in forms from a camp or school, they usually have information that the school or camps finds valuable to answer questions, concerns, or to have emergency treatment or information available such as bee sting allergies, etc. However, these forms were designed for the specific purpose of providing the school or camp with data and not to meet the coding requirements for your visit.

Often, past medical histories, social histories and family medical histories are alluded to, but done so incompletely or vaguely. The same is true for ROS. Therefore, I usually add in what I think is missing and simply relabel the forms with the headings I need to meet the coding requirements for the visit.

If no family history or social history section was present, I write in what is germane or I write “PMH/Soc: NC.” If they want an immunization list with dates and there are no other medical history issues, I write PMH in front of the immunization section. After all, that is what those injections are, a history of that patient’s medical care—and in some cases that a few ear infections are the only history except for the first two years worth of preventive medicine exams.

Again, work smart and do not do redundant work. Templates, yours or theirs, can save you valuable time. Use them and create your own where necessary.

Acute Issues with Preventive Medicine Codes (−25 modifier)
When deciding whether a preventive visit should be coded with an E&M service, you need to determine if the problem you would like to charge the outpatient codes (99201-99205 and 99212-99215) would have generated an office visit on its own. If the answer is yes, then you should bill and code the preventive visit first and the E&M code with a −25 modifier second (i.e.: 99213-25).*

You will need to have the V70 codes listed first on your encounter form and dictation and the other assessment(s) would be whatever acute issue(s) you found on the visit or that the patient complained about at the time of the visit.

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The Assembly Line Examination/Screening
Growing up in Florida, sports were king. As such, it was not acceptable for someone to miss an activity or sport due to missing the parental consent form or the school physical paperwork. These were required.

To make sure these were done my high school had one night each August where a dozen doctors and nurses donated their time and did an assembly line sports physical examination. There was no cost and all forms were collected on site. Anyone who even thought they were participating in everything from band to baseball was encouraged to attend.

In the screening occult hernias, hypertension, scoliosis, etc. was found. In some areas there are not enough providers to do these, while still others feel this is/was a poor substitute for a “real physical.” The merits of the quality can be debated, however, what cannot be debated is the payment for these services.

Assembly line work where one provider did not do the entire examination cannot and should not be billed out as a preventive or an acute visit. The latter could be billed if that particular provider found something that the patient wants to treat or work up, but this needs to be done to the letter.

While this is a convenient and kind thing to do, as many of my school mates would not have been able to get their exams done otherwise, check your malpractice and consider the night a donation.

Summary
Preventive exams come in many types. In adolescents, we often do not get the opportunity to do preventive work with them as they are less often seen except for these required visits for activities. Take advantage of these exams for what they are; a time for anticipatory guidance to discuss the importance of school, answer questions about sex or even to again find out about potential exposure to or use of controlled substances, etc.

We often look to these visits as a means to get caught up. What we should be trying to do here is to get caught up, not in our time schedule, but in the life of the student before us. Therefore, use these visits for prevention and bill accordingly.
New Injection Codes for 2002

Injection codes changed in 2002 and as such became more explicit in what they cover.

By Douglas J. Jorgensen, DO, CPC

Table 1Injection Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20550</td>
<td>Injection; tendon sheath, ligament, ganglion cyst</td>
</tr>
<tr>
<td>20551</td>
<td>Tendon origin, insertion</td>
</tr>
<tr>
<td>20552</td>
<td>Injection; single or multiple trigger point(s), 1 or 2 muscles</td>
</tr>
<tr>
<td>20553</td>
<td>Injection; single or multiple trigger point(s), ≥ 3 muscle groups</td>
</tr>
<tr>
<td>M0076</td>
<td>Prolotherapy</td>
</tr>
</tbody>
</table>

Table 2Body Regions as Designated Per Medicare

1. Head
2. Cervical Spine
3. Left Upper Extremity, Including Shoulder
4. Right Upper Extremity, Including Shoulder
5. Thoracic Spine
6. Lumbosacral Spine
7. Left Lower Extremity, Including Hip
8. Right Lower Extremity, Including Hip

If you have any coding questions that you would like Dr. Jorgensen to answer in upcoming Osteopathic Family Physician News publications, e-mail them to belindab@acofp.org.