

Cpt 99397 Denying With 90471

CPT 99397 Denying with 90471: Understanding the Reimbursement Challenges

The complexities of medical billing often lead to denied claims, and the interaction between CPT codes 99397 and 90471 is a prime example. Understanding why insurers might deny a claim involving these codes—specifically, why a 99397 might be denied when billed alongside 90471—requires careful consideration of medical necessity, coding guidelines, and payer-specific policies. This article delves into the intricacies of this common billing scenario, exploring potential reasons for denials, strategies for successful

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claims submission, and best practices for avoiding future issues. We will cover key areas like **medical necessity documentation**, **code bundling**, and **payer-specific rules** to help healthcare providers navigate this challenging landscape.

Understanding CPT Codes 99397 and 90471

Before examining denials, let's define the codes themselves. CPT 99397 represents a prolonged physician service, encompassing 30 minutes of face-to-face time beyond the usual time for a given E&M (evaluation and management) service. It's crucial for documenting the nature of this extended service—the complexities of the case, the patient's condition, and the medical decision-making involved. Conversely, CPT 90471 refers to the administration of a chemotherapy infusion by a physician or qualified healthcare professional. The crucial distinction is that 99397 addresses **physician time** and 90471 focuses on the **administration of a specific treatment**.

Common Reasons for Denial of 99397 with 90471

Insurers frequently deny claims involving both codes due to several factors:

1. Lack of Medical Necessity Documentation for 99397

This is the most frequent reason for denial. Payers need clear and concise documentation demonstrating the medical necessity of the prolonged physician service (99397) separate from the chemotherapy infusion (90471). Simply stating "prolonged service" is insufficient. The documentation must explicitly explain why the additional 30 minutes were required, such as:

- **Complex medical decision-making:**
The physician needed extended time to evaluate multiple complex issues related to the patient's condition and treatment plan.
- **Counseling and patient education:**
Significant time was spent addressing the patient's concerns, explaining the chemotherapy regimen, managing side effects, and providing emotional support.

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- **Extensive coordination of care:** The physician spent time coordinating care with other specialists, ordering tests, or arranging for necessary resources.

Without detailed documentation supporting the medical necessity of the additional time, the claim will likely be denied. This emphasizes the importance of **accurate medical record keeping**.

2. Code Bundling and Inclusion

Payers often consider 99397 to be inherently bundled into the global period of the chemotherapy infusion (90471). This means that the time spent administering and overseeing the infusion is implicitly included in the reimbursement for 90471. If the payer's policy views the prolonged service as an inherent component of the infusion process, the additional billing of 99397 will be deemed inappropriate. This issue necessitates an understanding of the specific **payer's policies and guidelines**.

3. Inconsistent Documentation and Coding

Contradictions between the documented clinical notes and the codes billed can lead to

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denials. If the documentation doesn't support the use of 99397, the claim will be denied regardless of the inclusion of 90471.

Maintaining clear and consistent documentation—where the clinical notes directly support the codes used—is paramount for successful claims processing. This also includes using appropriate **E&M codes** in conjunction with these procedures.

4. Lack of Preauthorization or Authorization

Some payers require preauthorization or prior authorization for both the chemotherapy treatment and for prolonged services. Failure to obtain this prior authorization may automatically result in denial of the claim. Always check **payer-specific requirements** for specific procedures.

Strategies for Avoiding Denials

To mitigate the risk of denials, providers should implement these strategies:

- **Detailed and Comprehensive Documentation:** This is the cornerstone of successful claims

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processing. Clearly articulate the reasons for the prolonged service, meticulously documenting the time spent on each activity.

- **Thorough Understanding of Payer Policies:** Familiarize yourself with each payer's specific coding guidelines, bundling policies, and requirements for preauthorization.
- **Regular Code Audits:** Periodically review claims submitted for compliance with coding guidelines and payer policies.
- **Invest in Medical Billing Software:** Sophisticated billing software can help identify potential coding issues and increase the accuracy of claims submissions.
- **Maintain Open Communication with Payers:** If a claim is denied, promptly contact the payer to understand the reason for denial and work towards a resolution.

Conclusion

Successfully billing CPT 99397 in conjunction with 90471 requires meticulous documentation, a deep understanding of payer policies, and careful attention to coding

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guidelines. By focusing on detailed medical record-keeping, proactive communication with payers, and adherence to best practices, healthcare providers can significantly improve their chances of accurate reimbursement and reduce the frustration of denied claims. The focus should always be on providing the best possible patient care, accurately reflecting that care in documentation, and understanding the specific requirements of each individual payer.

FAQ

Q1: Can 99397 ever be successfully billed with 90471?

A1: Yes, but only if meticulous documentation justifies the medical necessity of the prolonged service *beyond* the time inherently involved in the administration and monitoring of the chemotherapy infusion. This means clearly documenting complex medical decision-making, extensive patient counseling, significant coordination of care, or other extenuating circumstances that necessitate additional physician time. The key is to show that the additional 30 minutes were spent on activities separate from and above the normal care provided during the chemotherapy

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infusion itself.

Q2: What are the implications of consistently billing 99397 with 90471 inappropriately?

A2: Consistent inappropriate billing can lead to significant financial losses, potential audits, and even sanctions from payers. This can damage the reputation of the practice and negatively impact its ability to secure contracts with insurance companies.

Q3: How can I ensure my documentation supports the billing of 99397?

A3: Use clear, concise language that specifies the exact activities performed during the extended time. Use time blocks to illustrate the duration of each activity. Quantify the complexity of the medical decision-making, and explain any significant patient counseling or coordination of care involved. The documentation should directly support the medical necessity of the additional 30 minutes beyond the time already accounted for in 90471.

Q4: What if my claim for 99397 is denied? What steps should I take?

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A4: Review the denial reason carefully. Gather supporting documentation, and prepare a detailed appeal explaining why the denial is incorrect. If necessary, consult with a medical billing specialist or legal counsel. Clearly communicate with the payer, providing evidence that supports the medical necessity of the code.

Q5: Are there any specific resources available to help with CPT code understanding and billing?

A5: The American Medical Association (AMA) website provides detailed information on CPT codes, and many medical billing software companies offer resources and training on proper coding practices. Additionally, professional medical billing organizations and consultants can provide valuable assistance.

Q6: Does the type of chemotherapy administered affect the likelihood of a denial?

A6: While the specific chemotherapy regimen doesn't directly influence the appropriateness of billing 99397, the complexity of the patient's condition and the resulting need for extended physician time are key factors. A complex case might require more time for

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consultation, regardless of the specific chemotherapy agent.

Q7: Is it advisable to always bill 99397 with 90471?

A7: No. It should only be billed when the medical necessity of the additional 30 minutes of physician time is clearly and unequivocally documented and supported by the patient's clinical condition and the complexity of the care required. The billing practice must adhere strictly to payer guidelines.

Q8: What is the role of the medical coder in preventing denials involving 99397 and 90471?

A8: The medical coder plays a vital role in ensuring accurate billing by carefully reviewing the clinical documentation to verify the appropriateness of the codes. They should have a deep understanding of coding guidelines, payer policies, and the potential for code bundling. Effective communication with physicians regarding documentation requirements is essential to prevent denials.

The Perplexing Pairing: Understanding CPT 99397 Denials in Conjunction with 90471

The complex world of medical billing can regularly leave providers bewildered. One particularly tricky scenario involves the denial of CPT code 99397 (Extended Office Consultation) when billed alongside CPT code 90471 (Psychiatric diagnostic evaluation). This unfortunate combination frequently results in revenue loss for healthcare practitioners, making a thorough grasp crucial for seamless claim processing. This article endeavors to clarify the reasons behind these denials and provide practical strategies for preventing them.

The Core Issue: Code Overlap and Medical Necessity

The primary reason of denials when billing 99397 with 90471 stems from potential duplication in services. CPT 99397 represents a substantial office visit requiring substantial time and effort beyond a standard consultation. It's designed for complex cases

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needing extensive evaluation and handling. Conversely, CPT 90471 is a specific code for a psychiatric diagnostic evaluation.

The difficulty arises when the care provided during the visit mostly constitute the psychiatric evaluation itself. If the extended time and complexity described by 99397 are primarily attributable to the psychiatric evaluation already captured by 90471, the payer may view the 99397 code superfluous. This is because the lengthy evaluation is inherently part of a comprehensive diagnostic assessment, thus nullifying the need for an additional code for extended time. The payer might assert that billing both codes represents overbilling, leading to the rejection of the 99397 claim.

Illustrative Scenarios and Avoiding Denials

Let's analyze a few possible scenarios to better understand this sensitive issue.

- **Scenario 1 (Denial Likely):** A patient presents for a typical initial psychiatric evaluation. The session lasts 60 minutes, primarily dedicated to evaluation, history taking, and mental status examination. Billing both 90471

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and 99397 in this situation is highly likely to result in a denial for 99397 because the extended time is clearly related to the comprehensive psychiatric assessment already coded.

- **Scenario 2 (Denial Less Likely):** A patient with a history of depression presents for a follow-up appointment. During the 60-minute session, a significant portion is devoted to managing a severe medication side effect that requires thorough investigation and adjustment. While the visit includes elements of a psychiatric follow-up (which could potentially be coded using a different, more appropriate code than 90471), the major focus and time expenditure are related to the unexpected medication complication. In this instance, the justification for 99397 might be more compelling, making a denial considerably less likely, though proper documentation is still essential.

Key Strategies for Successful Billing

To reduce the chances of 99397 denials when utilized with 90471, the following techniques are vital:

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- 1. Meticulous Documentation:** This is the utmost important component of circumventing denials. The medical record must explicitly describe the character and scope of services provided. Specifically, justify the necessity for an extended visit. Highlight the precise reasons the visit exceeded a standard consultation.
- 2. Appropriate Code Selection:** Diligently choose the most accurate CPT codes to reflect the services performed. If the visit is largely focused on a psychiatric diagnostic evaluation, rely solely on 90471, and consider alternative codes to reflect other services rendered.
- 3. Understanding Payer Guidelines:** Different payers have different policies and standards. Familiarize yourself with your individual payer's guidelines on billing for extended visits and psychiatric evaluations.
- 4. Pre-authorization:** In some cases, pre-approval for extended visits may be required. Check your payer's requirements.
- 5. Appealing Denials:** If a denial occurs, carefully examine the reasons for the denial and draft a succinct appeal with comprehensive documentation to support your claim.

Conclusion

Billing CPT 99397 alongside 90471 requires cautious consideration and precise documentation. By thoroughly selecting appropriate codes, delivering comprehensive documentation, and grasping payer policies, healthcare providers can minimize the risk of unnecessary denials and guarantee prompt and correct reimbursement. The secret is exact documentation that clearly justifies the medical necessity of each code billed.

Frequently Asked Questions (FAQ)

Q1: Can I ever bill 99397 with 90471?

A1: Yes, but only if a significant portion of the extended visit time is dedicated to services in addition to the psychiatric diagnostic evaluation. The focus must be clearly on the additional, extensive medical services justifying the extended time.

Q2: What is the best way to document the medical necessity of 99397 when billing with 90471?

A2: Detail the precise clinical problems addressed, the actions taken, the time spent on each, and how these justify an extended

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visit in addition to the standard psychiatric evaluation.

Q3: What should I do if my claim for 99397 is denied when billed with 90471?

A3: Meticulously assess the reason for denial. If the denial seems wrong, prepare a well-documented appeal with supporting evidence from the patient's chart.

Q4: Are there alternative codes that might be more appropriate than 99397 in these situations?

A4: Yes, depending on the specific context, other evaluation and management (E&M) codes, or codes for specific procedures or treatments, may be more suitable to accurately reflect the services provided. Consult the CPT manual for guidance.

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