Debra Seyfried, MBA, CMPE, CPC

"Cloned" notes

Q What is a cloned note?

A A cloned note is found in electronic health records when information from previous encounters is used to document the current encounter, often with the exception of constitutional items. The latest work plan from the U.S. Department of Health & Human Services Office of Inspector General says the agency will be examining identical documentation across services as one practice that may be leading to potentially inappropriate payments.

Prolonged service

Q What is the proper code for a 90-minute face-to-face visit with a patient who presented with 12 diagnostic problems?

A Assuming the patient is established and the number of diagnostic problems led you to perform and document the key components required for a level-5 office visit, you should start by reporting code 99215, which typically represents 40 minutes of face-to-face time. Because the visit was 90 minutes, you could also report 99354, "Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (30-74 minutes)." Your documentation should state the total time you spent with the patient and include details that support the high level of service, including test results and options discussed. Your note should reflect the complexity resulting from the large number of diagnoses by documenting reasons for changes to treatment plans (e.g., change in medication for acute condition due to adverse effect on management of chronic condition).

Alternatively, if you spent at least half of the 90 minutes providing counseling or coordination of care, you could code the visit on the basis of time, which would also support billing 99215. In this case, you should document the total face-to-face time, the amount of time devoted to counseling or coordination of care, and a synopsis of the discussion. Code 99354 could also be billed.

About the Author

Debra Seyfried is the American Academy of Family Physicians' coding and compliance strategist. Author disclosure: no relevant financial affiliations disclosed. These answers were reviewed by members of the *FPM* Coding & Documentation Review Panel, including Robert H. Bösl, MD, FAAFP; Marie Felger, CPC, CCS-P; Thomas A. Felger, MD, DABFP, CMCM; Emily Hill, PA-C; Kent Moore; Joy Newby, LPN, CPC; Mary Thomas, RHIT, CPC; and Susan Welsh, CPC, MHA.

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Discharge day exam

Q What is the proper code for an exam given on a discharge day?

A Use 99238, "Hospital discharge day management; 30 minutes or less." This service includes components such as performing an exam, discussing the stay, providing instructions for continuing care, preparing discharge records, writing prescriptions, or completing referral forms. If the service is longer than 30 minutes, use 99239. Make sure you record the total time spent on discharge day activities in the patient's official discharge record.

Postponed pelvic exam and Pap smear

Q If I was unable to perform a pelvic exam and Pap smear during a preventive medicine evaluation and management service and performed them on a subsequent date, should I code for a separate visit?

A According to *CPT Assistant*, a pelvic exam and Pap smear are considered part of a comprehensive preventive service, and unless the patient has a separately identifiable issue, you should not charge for the follow-up visit.

Editor's note: This department attempts to provide accurate information, but some payers may not agree with the advice given. FPM

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