

CODING & DOCUMENTATION

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Commonly missed charges

Q We would like to conduct a chart review to determine if we are billing appropriately. Are there particular services that tend to go unreported and should be the focus of our chart review?

A Chart reviews are necessary for identifying missed charges and incorporating methods to better capture charges for frequently overlooked services. Some commonly missed charges are for venipuncture and laboratory services, other diagnostic tests (e.g., ECGs and pulmonary tests), medication administration (e.g., drugs, units, and administration fees), vaccine administration, home health certification, care plan oversight, and services provided outside the office (e.g., hospital and observation charges).

In addition to doing chart reviews, it is beneficial to routinely compare each day's completed appointments with the charges billed.

Previsit screening labs and "new patients"

Q If a new patient has venipuncture and screening laboratory testing performed by our clinical support staff prior to his or her first appointment with the physician, does this prevent us from reporting the E/M service as a new patient encounter?

A No, it does not because venipuncture and laboratory testing are not professional services as defined by CPT for determining whether a new or established patient E/M code should be used. CPT defines professional services as "face-to-face services rendered by physicians and other qualified health care professionals."

Note that a new patient is defined as one who has not received any services from the physician or another physician of the exact same specialty and subspecialty belonging to the same group practice within the past three years.

About the Author

Cindy Hughes is an independent consulting editor. Author disclosure: no relevant financial affiliations disclosed. These answers were reviewed by members of the *FPM* Coding & Documentation Review Panel, including Kenneth D. Beckman, MD, MBA, CPE, CPC; Robert H. Bösl, MD, FAAFP; Marie Felger, CPC, CCS-P; Thomas A. Felger, MD, DABFP, CMCM; Emily Hill, PA-C; Joy Newby, LPN, CPC; and Susan Welsh, CPC, MHA.

New problems during transitional care management

Q Can I submit a separate E/M code for an unrelated problem that surfaces during the face-to-face transitional care management (TCM) visit?

A No. All E/M services provided on the same day as the initial TCM face-to-face visit are included in the TCM service. The TCM service is not based on diagnosis; it is based on providing services to the patient transitioning to a home environment. The new problem, however, may increase the medical decision-making component of the TCM service. Any medically necessary face-to-face E/M services provided after the initial TCM visit could be separately reported.

Injury encounters in ICD-10

Q Under what circumstances is it appropriate to append the seventh character "A" vs. "D" when using ICD-10 to code an injury?

A You should report the code with seventh character "A" (initial encounter) only when there is active management of the injury or condition (i.e., when a pattern of healing is being established). This includes initial care of an injury for which the patient delayed treatment as well as evaluation and continuing treatment whether provided by the same or different physicians. Seventh character "D" (subsequent encounter) is reported for encounters after the patient has received active treatment and while receiving routine care during the healing phase, including such services as X-rays to determine healing status, medication adjustment, and follow-up visits. For more information about ICD-10, visit *FPM*'s ICD-10 Coding Topic Collection at <http://www.aafp.org/fpm/icd10>.

Editor's note: Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

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