Coding & Documentation

CME

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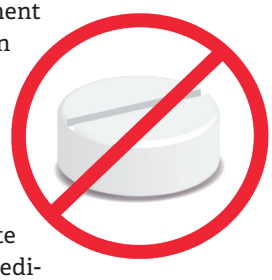
PRESCRIPTION DRUG MANAGEMENT AND E/M CODE SELECTION

Q For the purpose of selecting an E/M code, what level of medical decision making is associated with advising a patient to stop a medication?



A Any management of prescription medication (other than simply acting on a payer notice regarding a formulary change) qualifies as moderate risk, according to Medicare's Documentation Guidelines for Evaluation and Management Services. If the level of diagnosis and management options considered or the amount and complexity of data reviewed is also moderate or high, this would support a moderate level of medical decision making overall.

REVIEW OF SYSTEMS: HOW MANY SYSTEMS ARE TOO MANY?

Q My colleague advises always documenting a complete review of systems. However, this practice often provides little meaningful information. Is it recommended for coding and documentation purposes?

A No. A complete review of systems (10 or more systems) is only necessary if the patient presentation calls for a comprehensive history. In such cases, documenting a complete review of systems helps support the comprehensive history required for billing services such as level-five established patient office visits, level-four or level-five new patient office visits, and level-two or level-three initial hospital or observation care. You should consider only medically necessary documentation when selecting the level of service. A review of two to nine systems noting any positive and pertinent negative findings is often sufficient.

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.

DOCUMENTING EXAMS BY MEDICAL STUDENTS

Q Under Medicare's rules for medical review of student documentation, what must a teaching physician document when he or she agrees with the exam findings, assessment, and plan noted by the student?

A According to Medicare, after personally re-performing the exam and medical decision making, the teaching physician may review, sign, and date the medical student's entry in the medical record rather than re-documenting this work. Note that the physician should personally document any new or different findings or changes to the assessment and plan. (For information about additional documentation changes, see "The 2019 Medicare Documentation, Coding, and Payment Update," page 23.)

CODING FOR REMOVAL OF SKIN LESIONS: BIOPSY OR NO?

Q My patient had a lesion that was irritated by her waistband. I used a shave technique to remove the lesion and sent it to pathology for examination. Should I report this as a shave biopsy under the new CPT codes 11102-11103?

A No. A biopsy is performed if you intend to remove a portion of a lesion distinctly for the purpose of obtaining a diagnostic examination of the tissue. If your intent is therapeutic removal, report codes 11300-11313 for shave excision. Codes 11102-11103 represent tangential biopsy (removal of a portion of the dermis by a sharp blade) of a first/single skin lesion and each additional lesion from which tissue is obtained by tangential biopsy. Note that removing skin tags by any method is reported with code 11200 for up to and including 15 lesions and code 11201 for each additional 10 lesions after that. 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 affiliations disclosed.

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.