Debra Seyfried, MBA, CMPE, CPC

Documenting time

Q Is it necessary to document the time at the beginning and end of the patient encounter to show that the visit lengths included in CPT's office visit code definitions were met?

A Time spent with the patient needs to be documented only if the evaluation and management (E/M) code is time based (e.g., smoking cessation counseling or prolonged services) or if counseling or coordination of care accounted for more than 50 percent of the encounter and you are selecting a code on that basis. In both cases, you should document the total length of the encounter; if counseling or coordination of care dominated the encounter, you should indicate so and describe the reason for the service (e.g., "I spent 40 minutes with the patient and 28 minutes discussing his anxiety related to his recent job loss"). Specifically documenting start and stop times is required when billing prolonged services codes to Medicare.

Initial vs. subsequent nursing facility care

Q How should we decide when to use initial and subsequent nursing facility care codes for nursing home patients? Should we use the same codes for new and established patients? Sometimes our nursing home patients go to a hospital and then come back to the nursing home. Should we use an initial visit code each time they return to the nursing home?

A The initial nursing facility care codes, 99304-99306, are used to report the physician's first evaluation of the patient in the nursing facility. Subsequent nursing facility care codes, 99307-99310, are used for subsequent visits. Both sets of codes are equally applicable to new and established patients; whether the patient is new or established is not relevant when choosing an initial versus subsequent nursing facility care code.

When a physician discharges a patient from hospital inpatient or observation status, the appropriate discharge code should be submitted, and when the physician sees the patient in the nursing facility again, an initial nursing facility visit code should be submitted.

Modifier 52

Q When our annual wellness visit documentation does not meet Medicare's requirements, should we submit the annual wellness visit code with modifier 52 attached?

A No. Modifier 52 is for circumstances in which a service or procedure is partially reduced or eliminated at the physician's discretion, which does not seem to be the case in your situation.

Medicare annual wellness visit shortcut

Q For Medicare annual wellness visit documentation, I include a check box to indicate "Personalized health advice provided for health education to promote and improve well-being related to nutrition, mood, activity, and safety." Does this meet the documentation requirement for "Furnishing of personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services"?

A Partially. You should also document any referrals to a nutritionist or counselor.

Editor's note: While this department attempts to provide accurate information and useful advice, third-party payers may not accept the coding and documentation recommended. You should refer to the current CPT and ICD-9 manuals and the *Documentation Guidelines for Evaluation and Management Services* for the most detailed and up-to-date information. FPM

About the Author

Debra Seyfried is the American Academy of Family Physicians' coding and compliance specialist. 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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