CODING & DOCUMENTATION

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Coding based on time

Q I understand that physicians can bill E/M visits based on time or the levels of history, exam, and medical decision-making. If a physician billed the E/M service based solely on time but documented the history, exam, and medical decision-making, would that be acceptable?

A That would not be acceptable unless the documentation also indicated that the requirements for time-based billing were met. If more than 50 percent of the face-to-face time of the encounter was spent counseling or coordinating care, coding based solely on time is permissible. The key components of history, exam, and medical decision-making may be used to determine the level of any E/M visit and *must* be used if the visit doesn't meet the criteria for time-based coding.

The 1995 and 1997 E/M guidelines include differing instructions for coding based on history, exam, and medical decision-making, but the instructions for coding based on time are the same: Document the total length of the encounter (face-to-face or floor time, as appropriate), note that more than 50 percent of that time was spent providing counseling or coordinating care, and provide examples (e.g., "answered patient questions regarding withdrawal and weight gain and gave recommendations for diet and exercise in addition to smoking cessation plan"). Some payers may require documentation of both total visit time and an estimate of the time spent in counseling (e.g., 20 of 30 minutes).

Diagnosis coding and EHR documentation

Q Our electronic health record allows physicians to select a diagnosis code and then incorporates the code and descriptor into the progress note. Does the physician also need to list each diagnosis in the assessment portion of the note?

A Yes. Physicians must document a diagnostic statement and assign codes. Many diagnosis codes represent more than one condition, and code descriptors may lack the clinical specificity of a diagnostic statement. Physicians should also document symptoms that are considered integral to a condition and diagnoses that are suspected but not confirmed during the encounter. Guidelines do not allow physicians to code for this information, but documenting it is necessary for continued care. Physicians should *not* document a diagnosis included in the patient's problem list that did not affect management of the problems addressed at the current encounter.

ICD-10 "additional codes"

Q When ICD-10 instructs us to "use additional code," for example, to identify tobacco exposure, use, or dependence in category H65 for nonsuppurative otitis media, how should we report the *absence* of exposure, use, or dependence?

A First, reporting the absence of a condition is not required. Second, the "use additional code" note is a sequencing direction that indicates two codes may be required to fully report a condition. The code to which the "use additional code" note applies should be listed first when two conditions are reported.

Otitis media follow-up visit

Q What is the appropriate diagnosis code for a recheck for otitis media that finds the condition has resolved?

A Rather than reporting a current condition, report code Z09, encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm. Code Z86.69, personal history of other diseases of the nervous system and sense organs, could also be used to indicate the history of otitis media. FPM

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

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 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.

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