CODING & DOCUMENTATION

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Vital signs

Q How many vital signs must we document to count the constitutional system as an exam element when determining the level of an evaluation and management (E/M) service, according to Medicare's documentation guidelines?

A If you are using the 1995 documentation guidelines, you need only one vital sign. However, if you are using the 1997 guidelines, any three vital signs will count as one bullet in the constitutional system. The seven vital signs are sitting or standing blood pressure, supine blood pressure, pulse rate and regularity, respiration, temperature, height, and weight. General appearance is also an element of the constitutional system. Ancillary staff may measure and record vital signs.

Noncontributory documentation

Q When determining the level of an E/M service, should I include family history as noncontributory or unremarkable in assessing the level of service?

A The majority of Medicare administrative contractors (MACs) and some private payers have stated that "noncontributory" is not sufficient for documentation of the family history.

However, Novitas Solutions (a MAC) noted, "The use of the term 'noncontributory' may be permissible documentation when referring to the remaining negative review of systems. The term 'noncontributory' may also be appropriate documentation when referring to a patient's family history during an E/M visit, if the family history is not pertinent to the presenting problem."

Remember that for established patients, when you make no changes to the family history obtained at prior encounters, it is sufficient to document that fact (e.g., family history – reviewed, no change from 10/01/2015).

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; 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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Preoperative exam

Q What ICD-10 codes should we report for a preoperative exam?

A The first ICD-10 code listed for a preoperative exam is typically Z01.818, "Encounter for other preprocedural examination." List secondary codes to describe the reason for the procedure and any exam findings. However, if the exam is focused solely on the cardiovascular system (e.g., preoperative electrocardiogram), report code Z01.810. Likewise, report code Z01.811 for an exam focused on the respiratory system (e.g., pulmonary function testing). Note that you should report a preoperative chest x-ray with code Z01.818 because the chest x-ray does not focus solely on the respiratory system but also includes findings related to the heart and other structures visible on the x-ray. Report preoperative laboratory testing with code Z01.812.

FX modifier for x-ray

Q Are physicians required to append the new FX modifier to all codes for x-ray services?

A Modifier FX must be appended to codes for x-rays only if they were taken using film as opposed to digital imaging. A 20-percent payment reduction will apply to the technical component. Learn more from *MLN Matters* at http://go.cms.gov/2heQtDt. FPM

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

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