Coding & Documentation

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TECHNICAL DIFFICULTIES DURING TELEHEALTH VISIT

Q During an audiovisual telehealth visit, the connection was insufficient and I had to switch to audio-only (telephone). How do I report this encounter?

A This may depend on the payer. However, for Medicare patients and those whose plans adopt Medicare policies, you should report the encounter based on the technology used to provide *most* of the service. If you spent more time in medical discussion by telephone, report the telephone E/M service codes (99441-99443) in lieu of other E/M codes. During the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services is allowing equal payment for telephone E/M encounters and in-person E/M encounters (99212-99214). Telephone E/M visit codes are reported based on the time you spend in medical discussion with the patient, so be sure to document that time to arrive at the correct code.

SOCIAL DETERMINANTS OF HEALTH

Q I am hearing a lot about reporting codes for social determinants of health. When should I report them?

A After assigning a primary diagnosis, report codes for social determinants of health (SDOH) whenever social factors are incorporated into the medical record via documentation by the patient, clinical staff, or physician. SDOH codes should only be reported as secondary diagnoses. For instance, code Z59.02, "Unsheltered homelessness," may be reported secondary to codes for conditions managed at an encounter with a patient living in a park, on the streets, or in other areas not intended for human habitation. Note that SDOH count toward the risk element of medical decision making, affecting code selection, only if they significantly limit diagnosis or treatment. For example, homelessness increases risk when a homeless patient requires daily cleansing and redressing of a skin ulcer that cannot be achieved without reliable access to clean water and wound care supplies.

DISCUSSING IMPLANTABLE SUBDERMAL CONTRACEPTION

Q What codes should I report when a patient comes in to discuss implantable subdermal contraception (not implanted at this encounter)?

A When provided at a well-woman exam, discussion about contraception is included in the counseling that is part of all preventive medicine E/M services (99381-99387 and 99391-99397). However, when provided at a separate encounter where no contraceptive management (e.g., intrauterine device insertion) takes place, you may report time-based preventive medicine counseling codes (99401-99404) with ICD-10 code Z30.09, "Encounter for other general counseling and advice on contraception."

COVID-19 IMMUNIZATION

Q Is there a diagnosis code to indicate a patient has not been fully immunized for COVID-19?

A Not yet. But for services on or after April 1, 2022, you can use codes Z28.310, "Unvaccinated for COVID-19," Z28.311, "Partially vaccinated for COVID-19," and Z28.39, "Other under immunization status," for these patients.

CARE PLAN CREATION FOR PATIENT WITH COGNITIVE IMPAIRMENT

Q What documentation is required to support code 99483 for assessing a patient with cognitive impairment and then creating and sharing a care plan?

A A copy of the care plan that was created following the assessment must be part of the patient's medical record, and your documentation should indicate that a copy of the care plan was given to the patient or caregiver(s). (For an example of a care plan, see "Tools for Better Dementia Care" at https://www.aafp.org/fpm/2019/0100/p11.html#fpm20190100p11-ut3.) Your documentation should also include all of the other elements described by code 99483 (e.g., names and scores of standardized instruments used in staging for dementia and the assessment of neuropsychiatric and behavioral symptoms). 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 relationships.

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.

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