Coding & Documentation

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E/M AND ADVANCE CARE PLANNING IN SAME VISIT

Q When billing for an office E/M service and advance care planning on the same date, is a modifier required on the code for advance care planning?

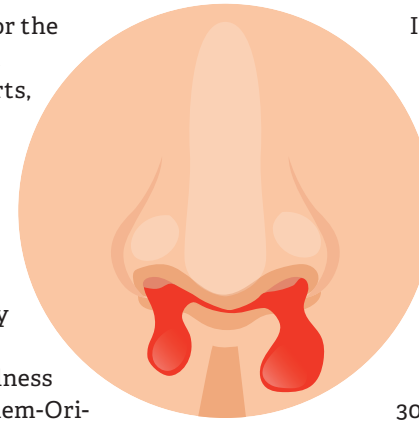
A Not typically. However, payers may require modifier 25 on the code for the office E/M service to signify that a significant and separately identifiable office E/M service was provided in addition to the advance care planning (CPT codes 99497 and 99498). If you use total time on the date of the encounter to select the code for the office E/M service, you cannot include any time spent on the advance care planning (including documentation) to determine the level of the office E/M service. If advance care planning is provided as a Medicare preventive service on the same date as an annual wellness visit (G0438 or G0439), append modifier 33 to 99497 for the first 30 minutes and, if reported, 99498 for an additional 30 minutes.

COMBINING A PROBLEM-ORIENTED VISIT WITH A PREVENTIVE VISIT

Q Should I choose a code for a lower-level office visit when I provide a problem-oriented office visit on the same date as a preventive medicine service?

A No. You should report the level of service that the documentation for the problem-oriented office visit supports, without overlapping the components of the preventive service. (For more on this, see the January/February 2022 *FPM* article "Combining a Wellness Visit With a Problem-Oriented Visit: A Coding Guide," https://www.aafp.org/pubs/fpm/issues/2022/0100/p15.html.) Some payers automatically decrease the payment for a problem-oriented E/M service on the same date as a preventive E/M service, so your payment could be significantly impacted if you bill a lower level of service than you provided.

The diagnosis code for the problem-oriented service should also represent a medical problem or concern for which a significant E/M service would be clinically indicated. Append modifier 25 to your problem-oriented E/M code to identify that you provided a significant and separately identifiable E/M service.



ANTERIOR NOSE BLEED

Q What code should I use to report controlling an anterior nose bleed in the office using compression and application of cotton soaked in oxymetazoline? No cautery or packing was required.

A Report the appropriate office E/M code based either on total time spent by a physician or other qualified health care professional or the level of medical decision making for the encounter. If control of a nosebleed requires cauterization and/or packing that is retained at the end of the encounter, see codes 30901-30903 for control of an anterior bleed or 30905-30906 for control of a posterior bleed.

TIME SPENT REVIEWING NOTES IN E/M CODING

Q When reporting my office E/M visits, can I include the time I spent reviewing and confirming my notes when I select the code for the visit?

A You can only count the time you spend completing documentation on the date of the visit. If you review and sign off on your documentation at a later date, you cannot include that time to determine the level of service.

For code selection, total time is the time on the date of the encounter that a physician or other qualified health care professional personally spends in activities related to the care of a single patient. This also applies to review of test results on a later date. Though part of the work of the visit, the time spent reviewing the test results is not included in the total time on the date of the encounter. Note that if you bill based on medical decision making instead of time, the review of test results would be considered part of the order and not counted separately. FPM

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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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