COFFEE & CODING

Monday, November 13, 2023

Answers to Your Coding Questions

Every week, we invite you to submit questions about what you read in Coffee & Coding or any coding-related issues you may encounter. This week, we'll answer a few questions we've received. We'll also pose a couple of our own.

Our first question (actually, two questions) stemmed from our recent issue on **"Level 5 Drug Therapy Requiring Intensive Monitoring for Toxicity."** A reader commented: *"The dictation advice seems more relevant for the outpatient world, since vital signs are always monitored frequently, and labs are also frequent in the inpatient world."* That prefaced these questions: "Is the guidance different for inpatient documentation? In your opinion, would a patient on Warfarin for DVT prevention be considered high-risk in terms of determining MDM (Medical Decision-Making) every day for extended stays?

Answer: There is no difference in documentation requirements between outpatient and hospital inpatient settings. And, yes, absolutely, a patient on Warfarin, Coumadin, or other blood thinners would qualify as high-risk in terms of medical decision-making because so many risk factors can impact the levels and because intensive monitoring is needed.

The next question comes from a physician in orthopedic practice. He noticed some differences in the new Telehealth and 99213-99214 codes for 2024 that needed clarification.

Answer: The changes for 2024 are not level-oriented. The big change is that, as of January 1, 2024, video is the only allowable means of communication for most Telehealth services. There are two notable exceptions to this rule change. Audio-only visits will still be allowed for mental health services and for patients in rural areas, where broadband access is generally less available.

Our third question also came from a physician regarding a recent office visit: *"I documented that the patient was three years old and came in with his parents. Why did I not receive credit in the Data Received portion of the MDM?"*

Answer: This case would fall under the requirements for Independent Historians since the patient was clearly too young to communicate the information for evaluation and management. The problem here was that, even though the facts you documented allow any reader to infer that the information came from the parents, the documentation must be explicit.

Per AMA guidelines, the dictation must clearly state that information was obtained from, received from, or given by an Independent Historian. Insurance company reviewers will look for such specificity in your wording; they cannot simply assume that the parents served as Independent Historians, even though you documented their presence and the patient's age. To ensure you receive credit for the services you provide, document everything explicitly and leave no room for inference.

Now a few questions for you:

We're conducting an informal poll among our readers:

1. What's the biggest challenge you face related to E/M leveling and documentation? Why?
2. What's the second-biggest challenge?
3. If there were one thing that could make that part of your work easier, what would it be? Why?

Please share your answers with us, and we'll let you know our survey results!

Got a question about E/M coding? We'd love to hear from you. Submit your questions by emailing us at coders@calmwatersai.com!

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