Monday, April 15, 2024

More Pro Tips & Tricks

Back by popular demand: We received such a positive response to our "tips and tricks" edition of Coffee & Coding that we've decided to make it a recurring feature each quarter. So, we invite you to grab a fresh cup of coffee and jump into a few topics that continue to elicit questions from coders and providers.

Review of Documentation /Records from Outside Facility

To receive credit for this, the documentation must state where the records came from and the date the review was performed. The provider must also specifically note that they reviewed the records independently. In other words, make sure that word appears somewhere in the documentation. Here's an example of how to do it compliantly: "I have independently reviewed the record from Mercy Hospital ER department on June 4, 2021, and the results were..."

To apply toward medical decision-making (MDM), you cannot use records from another physician within your facility. Nor can you count lab work ordered on another date, since you presumably billed and received credit for the orders at that time. (That would be double-dipping, and payors take a dim view of double-dipping.)

Scheduled Procedures = No E/M

If the patient's visit involves only an injection, vaccination, or procedure that was previously scheduled, then you can code and bill only for those procedures. Why? Because no MDM was involved. Typically, the decision-making would have occurred in a prior visit, and the patient then was scheduled for a return appointment. Example: The patient was seen for arthritis of the left thumb two weeks ago and was scheduled for an injection-only appointment the following week. If nothing but that injection was addressed during the follow-up appointment, you cannot bill for an E/M office visit.

On the other hand, let's say the patient comes in for an injection appointment and mentions a sore knee, and the doctor or PA examines it. In this case, you may bill for an additional E/M office visit because the evaluation involved a different issue or body part than the purpose of the scheduled visit.

Prolonged Services

Let's say the provider spends additional time with a patient on the date service BEYOND the total time requirement for the highest level primary E/M service within the category. Often, providers spend this extra time in direct patient care or managing complex cases. You would use CPT® add-on codes +99417 or +99418, depending on whether the service happened within an outpatient or inpatient setting. How do you meet the requirements for these codes so you can bill for prolonged services?

The E/M service can involve direct or indirect patient contact, and the provider must spend **at least** 15 minutes beyond the total time indicated for the E/M services code. You'll record the added time in 15-minute units. For example, let's say the service involves a new patient office visit or another outpatient encounter (99205), which allows for 60 minutes. If your provider spends at least 75 minutes on the encounter on that service date, but not more than 90 minutes, you can record an initial unit of prolonged services. If the encounter requires at least 90 minutes, you can add a second unit of prolonged services. If you're coding for an established patient office visit (99215), you can add a unit of prolonged services if the encounter requires at least 55 minutes (15 minutes beyond the allotted 40) on the encounter date.[1]

Telehealth Requirements

Telehealth is relatively easy, as long as you document five main components to bill for these visits.

1. Document the location of the physician.
2. Document the location of the patient (they are not always at home; they might be at work or even in their car).
3. Document the method of the call. Was it both video and audio, or audio only? Did the video fail during the visit, and did the encounter finish as audio only? You have to note that, too.
4. Document permission, confirming that the patient is aware that these are secure platforms; that the information is confidential (HIPAA) applies); that it is a permanent part of their record; and that the patient understands the purpose, benefits, and limitations of telehealth services.
5. Always document the time of the call even if you are not billing based on time. Sometimes, it may be more advantageous to bill the call by time rather than by MDM.

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[1] AAPC Knowledge Center, https://www.aapc.com/blog/90003-billing-prolonged-services-in-2024/