Calm Waters AI

COFFEE & CODING

Monday, April 29, 2024

More E/M Coding Questions (and Answers!)

This week, we pick up where we left off with the last issue of Coffee & Coding, when we addressed questions about how tests and lab work can count toward complexity of data in medical decision-making (MDM).'

The Role of Coders in Assessing Changes in Medical Conditions

Short answer: There is no role for coders here, even when making an educated guess based on the provider's documentation is possible. Only the patient's physician or other qualified health professional (QHP) should determine whether a medical problem or illness is stable or worsening. And that assessment occurs during the patient encounter reported by the provider.

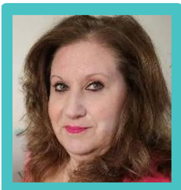
Documenting by Time vs. Level of MDM

It depends. As a basic rule of thumb, use whichever method that accounts for the most appropriate and relevant elements for the particular patient encounter. A time-intensive visit may warrant billing by time rather than MDM. Conversely, you may be better off using MDM for a shorter but high-intensity encounter.

Specifically documenting whether a surgery is major or minor.

This is an "always" rule: Providers should clearly indicate whether a surgery is "major" or "minor." Note, however, that these terms are not defined by the CPT coding's surgical package classification. Instead, the classification depends on how trained clinicians commonly apply them.

[1] American Medical Association, CPT Evaluation and Management Revisions FAQs: https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management-em-revisions-faqs



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