11 Common Coding Questions (and Their Answers)

By Steph Weber
What are the documentation requirements for coding by time?

"The documentation must include the total time of the visit, a summary of the discussion/counseling, [and] support that greater than 50 percent of the visit was spent in counseling or coordination of care. Some [payers] allow a statement of greater than 50 percent of the total time was spent in counseling, while others require the amount of counseling time be documented in minutes. The total time is utilized to determine the appropriate code."

Angie Babb, senior manager of physician coding at Blue & Co., LLC, a healthcare consulting firm in Indianapolis, Ind.
What is the CPT code for a phlebotomy done in office unilaterally and bilaterally?

"A phlebotomy is for treatment of dramatically imbalanced blood levels (e.g. hemoglobin or potassium salts). Bilateral procedure rules do not apply since drawing blood isn't related to any body part or extremity, just blood level. Use 99195 phlebotomy, therapeutic (separate procedure) as the correct code."

_Tatyana Kantor, education department manager at WCH Service Bureau, Inc., a medical billing and credentialing company in Brooklyn, N.Y._
Can I charge for an office visit during transitional care management time?

"The transitional care management codes (99495-99496) include one office visit. If you provide additional office visits during the 29-day period after hospital discharge, you may charge the appropriate level evaluation and management (E&M) code for the service(s) provided."

Amy Poplin Dunatov, a medical practice consultant and documentation auditor, in Raleigh, N.C.
What components of the E&M documentation can my clinical staff document in the chart?

"Most Medicare carriers require that the ancillary staff only record the review of systems and the past/family/social history components [of the chart]. Keep in mind that the review of systems documentation should be an accounting of how the patient's organ systems are being affected by the presenting problem. Words such as unremarkable and noncontributory are not acceptable forms of ROS documentation."

Amy Poplin Dunatov, CCS-P
"The 99215 code [allows] for 40 minutes spent face-to-face with the patient and or family. However, the code is not time-based. In order to use this code, the visit must meet two of three components. It should include a comprehensive history of the patient, a comprehensive examination, or medical decision-making of a high complexity. If these requirements are met, even if the visit is less than 40 minutes, the code can be assigned."

Tatyana Kantor, CPC
If a nurse practitioner (NP) sees a Medicare patient for an established problem and during the encounter the patient brings up a new issue, can this visit be billed as "incident-to"?

"New patients and new problems for established patients do not meet the guidelines for an 'incident to' visit. If an established patient has a new problem, the provider has two options: 1) The NP may bill the visit under their individual NPI, or 2) the NPP may ask the supervising physician to come into the room for a face-to-face visit with the patient, [document] their portion of the visit, and bill as a shared service visit."

Amy Poplin Dunatov, CCS-P
What are the documentation and medical necessity differences between 99213 and 99214?

"99213 represents an established patient visit of low complexity and 99214 represents an established patient visit of moderate complexity. Patients who present with conditions/illnesses that are uncomplicated in nature and will usually follow a predicted resolution path are typically reported with 99213. Patients who present with more complex conditions/illnesses that may require additional follow-up or medical management are typically reported with 99214."

Angie Babb, CPC
What is clinical plagiarism?

"Clinical plagiarism occurs when a physician copies and pastes information from the chart [of] another provider and calls it his/her own. This has become an increasing problem in medical documentation. Care should be taken to make each documentation entry specific to the patient's problem and not copied from another entry. Providers should further understand how macros and templates they are using look when the medical record is complete."

Amy Poplin Dunatov, CCS-P
How do I charge for a procedure that was started but not finished due to the patient being uncooperative or at risk?

"Depending on the type of procedure, you may be allowed to use the procedure code with a modifier -53 (discontinued procedure). You should verify with your specialty society whether it is allowed. Also, each insurance carrier may have specific rules about the use of modifier -53. At a minimum, be prepared to provide medical records [that detail why] the procedure was started [and] discontinued and what percentage of the procedure was completed."

Amy Poplin Dunatov, CCS-P
Why is my superbill being returned?

"A biller will return a superbill because [it is] incomplete or illegible or [needs] to be signed in case of an audit. [Physicians] need to provide as much detail as possible for each visit. For example, 'finger fracture' is not enough. A biller can't assume which finger it is, what part of the finger was fractured, or if a service was an active or subsequent treatment."

Tatyana Kantor, CPC
What should I do if a patient is unable to provide history due to dementia or unconsciousness?

"The 1995 and 1997 E&M guidelines allow the provider to document that the patient is unable to provide the history and receive credit for a comprehensive history. However, if a family member, caregiver, or other reliable source for information is available (even by telephone), the physician should pursue that resource. Documenting 'unable to obtain' is sufficient from a coding/documentation standpoint, but the physician should try to collect as much information as possible about the venerable patient for treatment purposes and to reduce malpractice risk."

Amy Poplin Dunatov, CCS-P