Coding Conundrums

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namas national alliance of medical auditing specialists

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Auditor, Coder, Consultant, Trainer, National Speaker

Partner, DoctorsManagement

President, National Alliance of Medical Auditing Specialist

Always worked in healthcare

Trained as a Respiratory Therapist and practiced for 8 years

Onboarded with DM 20 years ago | Partner 13 years ago

Founded NAMAS 18 years ago

Established the CPMA & CEMA credential

Currently reside in Merritt Island, Florida

Married with 3 kids (25, 24, and 23) 3 dogs (Goose, Noodle, and Flo), and 1 cat (Maxx)

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DOCTORS MANAGEMENT

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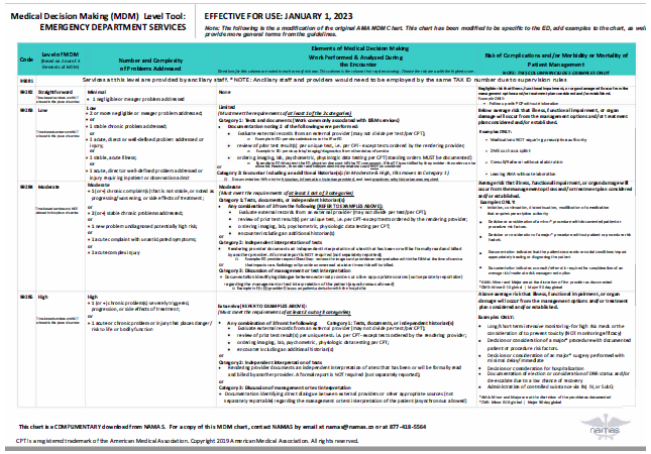
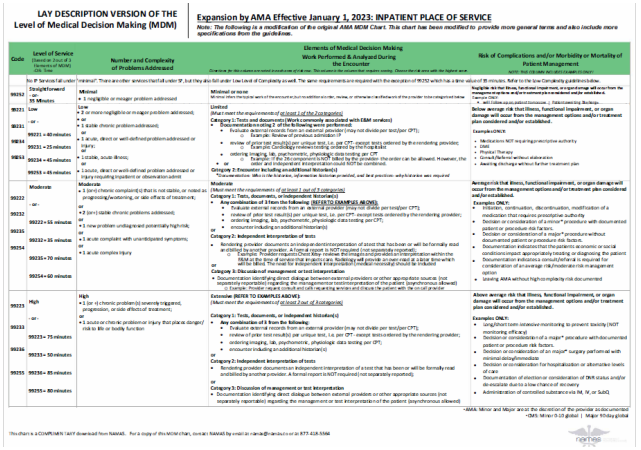
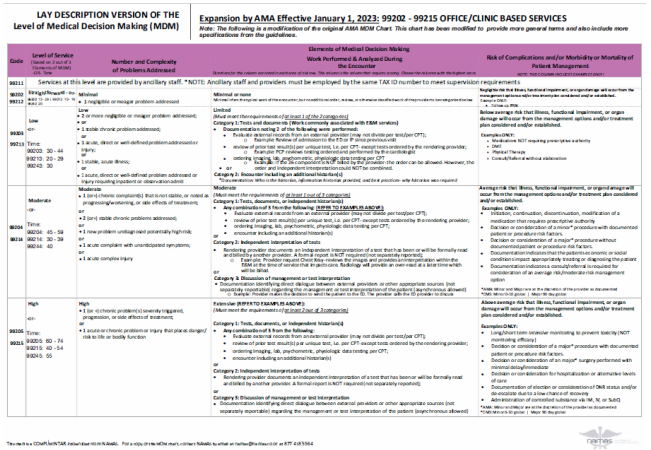

Medical Decision Making (MDM) Level Tool: EMERGENCY DEPARTMENT SERVICES

EFFECTIVE FOR USE: JANUARY 1, 2023


LAY DESCRIPTION VERSION OF THE Level of Medical Decision Making (MDM)

Expansion by AMA Effective January 1, 2023: INPATIENT PLACE OF SERVICE


LAY DESCRIPTION VERSION OF THE Level of Medical Decision Making (MDM)

Expansion by AMA Effective January 1, 2023: 99202 - 99215 OFFICE/CLINIC BASED SERVICES

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Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

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Audra the Auditor Asks…

- Recently while reviewing pediatric cases, documentation was reviewed that implied the physician visualized the patient during the telehealth visit.
- Upon research, there was no documentation in the notes that the patient was seen or visualized, although there were notes about the discussion with the caregiver about the signs and symptoms in these cases.
- How specific does the provider have to be?

Yuling is having trouble when reviewing a certain style of note…

With the 2021 guidelines, one grey area that we are unclear of is the difference between: “1 undiagnosed new problem with uncertain prognosis” (level 4) vs. “1 acute, uncomplicated illness or injury” (level 3). An example:

S: Complaining of right ear pain. This started about 2 days ago, worsened last night. Mom treated with ibuprofen, she notes that she came to her later in the evening with a draining ear and reported the pain had improved. She has had a cold for several days which mom thought was improving.

O: She is seen in the office accompanied by her mother. She appears generally well. T: 97.3. Wt: 52 lbs.

Ears: Left canal is clear, TM is injected, decreased mobility on insufflation but no pain. Right canal is clear, TM is shiny but erythematous, there is pain on insufflation. Perforation likely by history, but not grossly visible.

A/P: Bilateral acute otitis media with perforation on right. Amoxicillin 250 mg chewtabs, 3 tabs 3 times daily x10 days. Follow-up in 1 month. Time spent: 15 minutes.

My “opinion”, is that an ear infection is an acute uncomplicated problem, but the providers office appealed and identified it as “undiagnosed new problem with uncertain prognosis”.

Sabrina is frustrated…

Is visualization of images on independent interpretation of testing required to be documented in order to count in the MDM?

We have no claims policy indicating it does, so I am looking for authoritative guidance.

Chandler's Team needs help…

- Can you, once and for all define RX Management vs. OTC use?
- Please consider terms and documentation usage such as continue medication.
- What really counts as RX management?

Glenda wants to know

- Is medical necessity still “a thing” in 2021 or will MDM compensate for that pattern in our auditing?

Gerald asks…

I am asking for thoughts on pre-populated check boxes or templated documentation that indicates labs and/or imaging has been reviewed through validation of them checking the box.

There is a MACRO statement that populates in the note, however, it is the same statement in all notes, and is not specific.

Thoughts?

Justine asks...

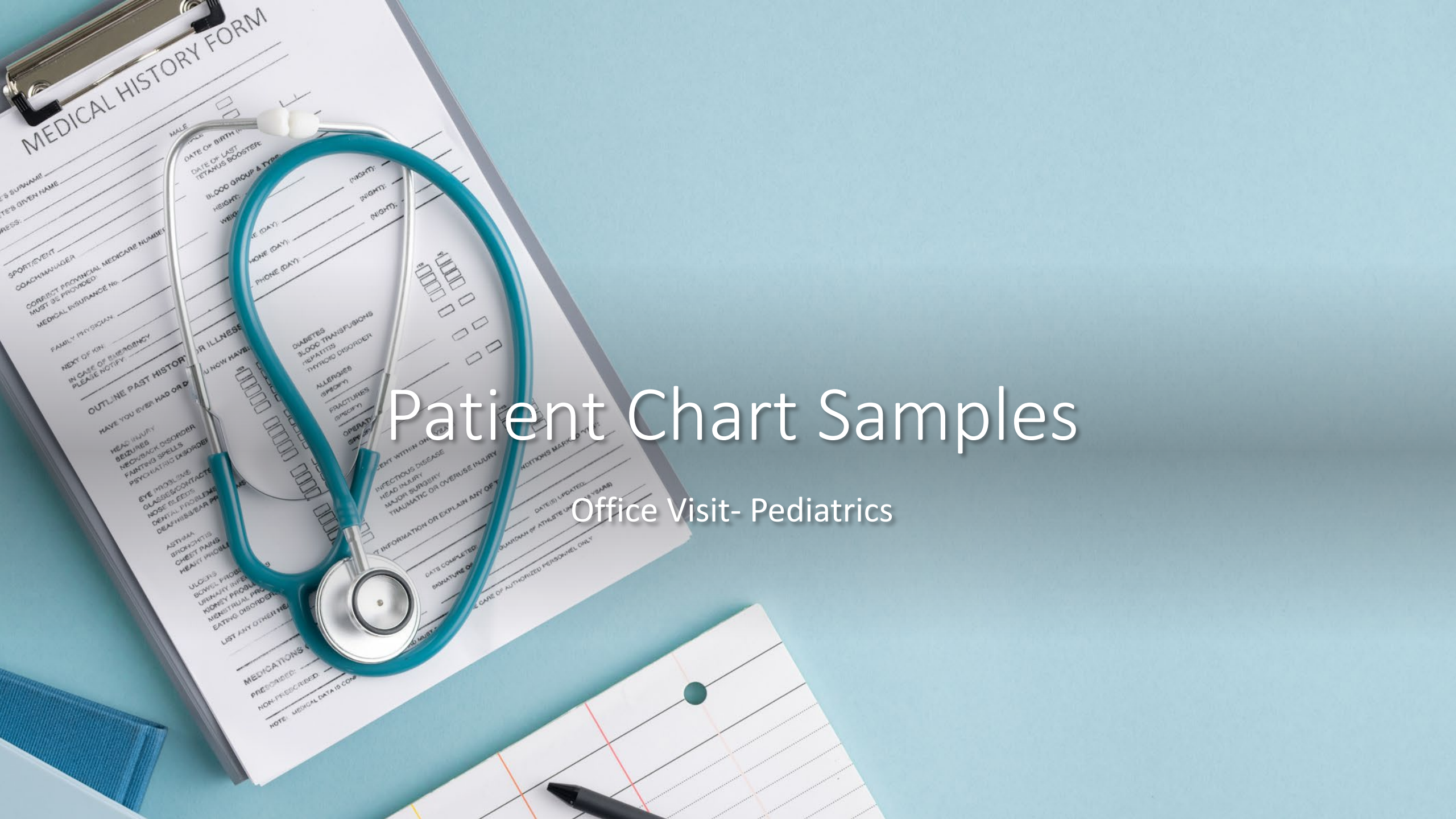
At what point is a presenting problem considered as a problem addressed?

Shakira Asks…

What are some examples of issues that would be eligible for separate E&M coding on the same day as a procedure such as wound care?

Haley asked Vanesha, and then they both asked…

Can you please discuss the separation of Preventive Exams and New Problem relevant to 2021 Guidelines?



Patient Chart Samples

Office Visit- Pediatrics

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Serving Patients in POS 11

PERRY, MARK
15 Y old Male, DOB: 06/27/2006
Account Number: 67457
14 SURPRISE WAY, LAKE COAST, FL-32444
Home: 999-999-9999

09/13/2022 Progress Note: MARY HEALY, ARNP

Current Medications
None

Past Medical History
Medical History Verified.

Surgical History
No Surgical History documented.

Family History
Mother: alive

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
No Hospitalization History.

Review of Systems
CONSTITUTIONAL:
no Fever. no Chills. no Weight Loss. no Weight Gain. no Loss of Appetite.
CARDIOLOGY:
no Chest Pain/pressure. no Palpitations. no Dizziness/lightheaded. no Leg Edema.

DERMATOLOGY:
no Lesion. no Itching. no redness. no Rash.
NEUROLOGY:
no Headache. no Weakness. no Tingling/Numbness. no Visual Changes. no Dizziness.
RESPIRATORY:
no snoring. no Shortness of Breath. no DOE (dyspnea on exertion). no Persistent Cough. no Chest Congestion.

Reason for Appointment
1. SINUS ISSUES - STARTED SWIM TEAM - TELEMED FACETIME

2. Pt had tested for covid at the Agriculture Center In St John's county today is negative.
3. Pt is taking over the counter Nasal saline spray,

Assessments
1. Acute rhinitis - J00 (Primary)

Treatment
1. Acute rhinitis
Start azelastine nasal spray, 137 mcg/inh, 2 spray(s), intranasally, 2 times a day, 30 day(s), 1 Bottle, Refills 1
Notes: Recommend Ayr saline spray/gel 2-3 x a day; may try 2nd generation antihistamine.
Montior for worsening w fever, purulent dc, not improving.
Exposure in pool/swimming, symptoms may persist.

2. Others
Notes: Time with patient on televisit was greater than 12 minutes with 50% of the time involved in treatment plan and coordination of care. Patient is informed that an in-person visit with the doctor may discover additional findings, diagnostic and treatment options not considered in a Televisit.

Follow Up
prn,Please keep all previously scheduled appointments with providers

History of Present Illness
Follow-up:
Telemed Visit:
Patient has given verbal consent to be treated virtually.
Interactive Visual and audio connectivity was obtained by-Facetime.
I am in my St. Augustine, FL office, and the patient is at their home.
Participants in this telemed visit were-myself: Mary Healy, APRN and patient/mother .
Explained quarantine restrictions and the prevention of transmission of CoVID 19 communicable disease by utilizing the process of televisit for assessment, ROS and verbalized understanding to the best of their ability.
Est pt w c/o sinus pressure, congestion onset last Friday. On swim team, recently started. Using Afrin and nasal saline.
Afebrile, denies sinus HA, pain.
Stable.
ENT:
c/o NASAL CONGESTION. c/o POSTNASAL DRIP. c/o RHINITIS. Denies : COUGH. Denies : EAR PAIN. Denies : EAR DRAINAGE. Denies

: SORE THROAT. Denies : EYE SYMPTOMS. Denies : FACIAL PAIN. Denies : HEADACHE. Denies : SWOLLEN LYMPH NODES. Denies : SICK CONTACTS. Denies : OTC MEDS. Denies : FEVER.

Vital Signs
Ht 67, Wt **117**, BMI **18.32**, Temp **97.9**, INITIALS **JR/verbal consent given by pt.**

Examination
General Examination:
General Appearance: NAD, pleasant, non-ill appearing. SKIN no perioral cyanosis. HEENT: Head - NC/AT, sclera anicteric, clear conjunctiva. Lungs: regular breathing rate and effort. Neurologic Exam: alert and oriented x 3, non-focal exam.
Psychology:
Mood : pleasant.

Visit Codes
99203 New Patient Level 3. Modifiers: 95

Care Plan Details

Electronically signed by Mary Healy on 09/14/2022 at 08:52 AM
Electronically co-signed by John Skaggs, MD on 09/20/2022 at 11:29 PM EDT

Sign off status: Completed

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Patient Chart Samples

Office Visit- Ortho

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Chief Complaint right hip pain and low back.

History of Present Illness

The patient is a 83 year old female seen today for the right hip pain and low back.The symptoms have been present for 2 weeks. Pain is moderate with a rating of 8/10. Since the onset, she reports the problem is getting worse. Prior testing: No diagnostic tests have been performed.
Patient is a 82-year-old female with right hip pain that radiates from the lateral aspect of the hip down towards the knee for 3 weeks now. She does have some known knee problems and had arthroscopy a year ago in the past for that. She did have a cortisone injection in that knee as well. She has some low back pain but not significant. She had denies any numbness or tingling in the foot or lower leg. She denies any changes in bowel or bladder habits.

Conservative Care History: No prior treatments to date.

Medical History

Medical Conditions: Breast Cancer, Arthritis, High Cholesterol, Chemotherapy (Z92.21)
Current Medications: omeprazole 20 mg capsule,delayed release 1 cpDR oral as directed, atenolol 100 mg tablet 1 oral as directed, primidone 250 mg tablet 1 oral as directed, simvastatin 10 mg tablet 1 oral as directed, lorazepam 0.5 mg tablet 1 oral as directed
Allergies: No known allergies

Surgical History: cataract (eye) surgery, mastectomy and malignancy/cancer removal. Tonsilectomy arthroscopy of the right knee, arthroscopy of the left knee, arthroscopy of the right shoulder and rotator cuff repair on the right. Bone spur heel

Family History: Father: None.
Mother: None.
Sibling(s): None.

Personal and Social History: The patient does not smoke. The patient currently does not consume alcohol.

Review of Systems

Constitutional: The patient denies any unplanned weight loss, loss of appetite, fatigue or weakness.
Eyes: vision loss.
Ear/Nose/Throat: The patient denies any hearing loss, hoarseness, trouble swallowing, ear pain/ringing, tooth/gum issues or nose bleeds.
Cardiovascular: The patient denies any chest pain, palpitations, heart attach or high blood pressure.
Respiratory: The patient denies any chronic coughing, pulmonary embolism, pneumonia or shortness of breath.
Gastrointestinal: Patient denies heartburn, nausea, blood in stool or stomach pain.
Genitourinary: The patient denies any painful urination, blood in urine or kidney problems.
Skin: The patient denies any rashes, skin ulcers, lumps or psoriasis.
Neurological: The patient denies any frequent falls, loss of coordination, numbness, blackouts, frequent headaches, dizziness, change in bowel or bladder function.
Psychiatric: The patient denies any depression, drug addiction, alcohol abuse or sleep disorders.
Endocrine: The patient denies any fever, heat/cold intolerance or night sweats.
Hematological: The patient denies any bleeding problems, easy bruising, anemia or DVT.
Musculoskeletal:
The patient denies any osteoarthritis, muscular weakness or muscular pain.

Vital Signs: Height: 5ft 2.00in, Weight: 159lbs BMI 29.08 Pulse Blood Pressure

General Exam:

Constitutional:

Patient is adequately groomed with no evidence of malnutrition.

Mental Status:

The patient is oriented to time, place and person. The patient's mood and affect are appropriate.

Right Hip/Pelvis Examination

Inspection: There is no swelling or ecchymosis. There is no obvious deformity.

Palpation: There is marked trochanteric tenderness.

Range of Motion: There is almost full ROM which some pain at the extremes.

Strength: Hip strength testing 5/5 in all muscle groups tested.

Sensation: Sensations are intact.

Reflexes: Reflexes are normal and symmetrical.

Special Tests: Stinchfield and Trendelenburg tests are negative.

Gait: Antalgic gait favoring the affected side.

Lumbar Spine Examination

Inspection: There was normal alignment of the lumbar spine

Palpation: There is no tenderness in the lumbar region. There is normal tone with no spasm noted.

Range of Motion: Range of motion of the lumbar spine was within normal limits.

Strength: There was 5/5 strength of the lower limbs..

Sensation: Sensation of the lower extremities is intact.

Reflexes: Lower extremity reflexes are intact and symmetric.

Special Tests: Dural stretch testing is negative.

Gait: Gait and station are normal without the use of an assistive device.

Additional Comments: she has full range of motion of the right hip. No significant groin pain with range of motion

Imaging Orders: 2 views of the lumbosacral spine were ordered, obtained and interpreted from an orthopaedic standpoint. 3 views of the pelvis were ordered, obtained and interpreted from an orthopaedic standpoint.

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Lumbosacral Spine Xrays: Some lumbar degenerative disc disease with appears to be degenerative scoliosis. **Hip/Pelvis Xrays:** No significant hip arthritis. No evidence of any bony lesions. She does have some calcification right over the right greater troch area probably secondary to the bursitis

Diagnosis Codes: M70.61 Trochanteric bursitis, right hip, M54.59 Other low back pain

Impression: Right hipTrochanteric bursitis
Lumbar Pain

Office Procedures: The Right Hip Superior trochanter area was cleansed in preparation for injection. The Right Hip Superior trochanter was injected with and 3 cc of 0.25 marcaine and 20 mg of Kenalog. The patient tolerated the procedure welland a Band-Aidwas placed.

Treatment Plan:I feel her primary problem today is trochanteric bursitis. We did discuss treatment options for this to include a trochanteric bursa injection. She would like to proceed with this. I would like to see her back on a p.r.n. basis. I would like to x-ray her hip today as well after the injection.

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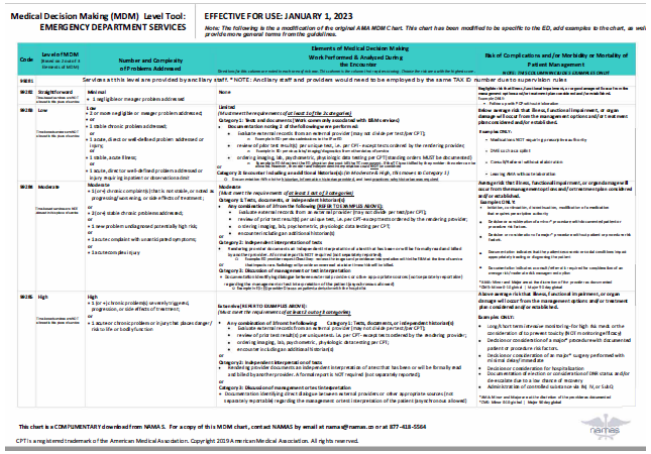
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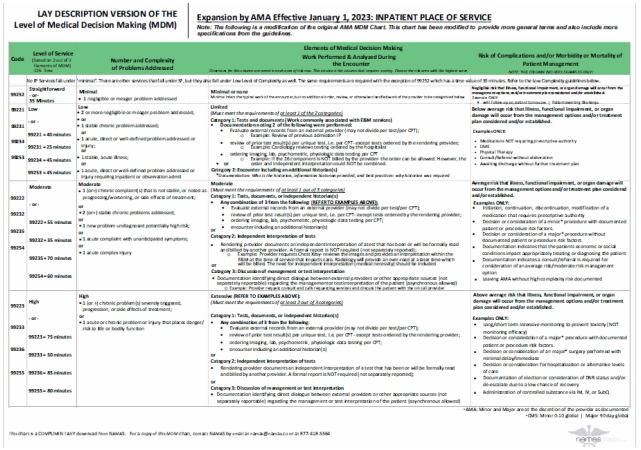
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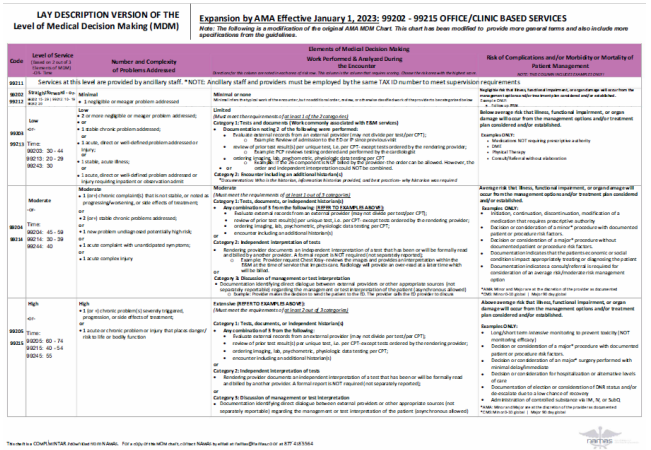
Expansion by AMA Effective January 1, 2023: INPATIENT PLACE OF SERVICE


LAY DESCRIPTION VERSION OF THE Level of Medical Decision Making (MDM)

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Questions?

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