Q&A_E/M Coding & Documentation Changes | What We've Learned	
Question Asked	Answer Given
I'm confused about Covid. We don't know the diagnosis until test result is back. So symptomatic Covid is complicated (prognosis unknown). And if positive there is inherent risk for complication?	This is a tough one. When you pick a problem when they are COVID you just changed the diagnosis. If you get the answer/result back that day you want to code to the most specific diagnosis. If this is a kid that you have seen back twice then that is a different story. Remember it is a risk for the patient and not the family.
Isn't counseling on isolation and quarantine for potential Covid increasing risk to at least low 99213? Just like rest and fluids, diaper cream, Tylenol (as per AAP quick reference) are low.	That's a squishy one. That's a great question for the coding hotline. It's always good to get guidance from the coding hotline.
Does the AAP still stand by increasing code for OTC weight based meds to moderate.	You have to make it relevant. If your going to count an OTC med is a level 4 managing risk, it is justified but connect the dots for an auditor. Use words like "increased risk of titrating based on weight for this patient", "Over the counter dosing not available for this age group" discuss the benefits of the dosage and medication.
What is the number to coding support?	See slide 30
If the MA/nurse enters the HPI/ROS and the provider feels that it is accurate, does the provider need to write anything else other than "Provider reviewed HPI and ROS information entered by MA/nurse" now that HPI/ROS is not included in billing requirements?	You don't even have to write that information unless you feel more comfortable doing that for medical/legal reasons. If it is important for you to communicate that to your colleagues then document it. Decide why are you are doing this? Is it important for you to know that for medical/legal documenation or were you checking the box to get coding credit? Possibly rethink this.
Do you think you should document the time spent in the note or is the audit sufficient?	Ask yourself if you were audited, would it be sufficient. If the documentation is there then yes. It's always better to document. I think that if you smart enough to send the audit note the audit note will be enough.
Any thoughts on when a response from AAP might come with regards to in house tests and use as a dtat point	No at this time.
How would you determine proper MDM for a pre-op exam?	This would be dependant on your Payer. Good question for the coding hotline. Mostly these would fall on 99213's

if this has already been addessed I apologize and you can answer offline. I've been in and out seeing patients. We struggle with the level 4 risk category. Can we get some examples of moderate risk from additional testing or treatment besides writing RX	See slide. What about risk? In addition to what is on the slide remember to document and make clear what it is you are thinking according to your plan.
Is it reasonable to think thatt for a baby / young child that can not give their own history that you do not need to write "Mom reports..." etc?	It is reasonable. No one knows where that age band is. I would still put in the independent historian who it was in the note, but an auditor is not going to expect the child to answer that. We don't know where that stops so when in doubt spell it out. Have it in the note who gave that information.
If Time and MDM give you the same code, is it better to code by MDM or does it not matter? And is it necessary to attest time if you are coding by MDM?	Use the code that is higher, just make it clear which code you pick. Make sure your documentation is there on which code you selected. If it's not clear the auditor will select the code that is clear.
which z codes work as stand alone codes -ie school underachievement etc	See slide "What about Z Codes? It depends!" In addition to what is on the slide remember to document and connect the dots in your note. Stand alone vs the second diagnosis. If it is a stand alone code it would be Payer dependent if they would pay. If it is a secondary diagnosis, absolutely but verify your documentation is there for the code. Some people ask about the Z code for family disruption you need to make sure that the code is sufficient for diagnosis or treatment. Connect the dots in your note.
How to I convince my providers that clicking "weight loss" in the ROS isn't enough but needs to document instead?	Would suggest printing out a note and showing them an audit of the note. How does this look to another Provider or someone who may audit this note. Somehow you need to document it in the plan or make it a diagnosis. ROS is not enough and is not counted.
You mentioned documenting family history ie: no family history of cardiac disease for sympotm of chest pain. Is it adequate to just "review" family history tab in chart or does it need to be explicitly stated in note. Thank you	So you don't get credit for reviewing family history. That example is an example of the independent historian who was providing valuable data, so checking any boxes in the history would be to help you in a legal disput.
Am I the only one still confused what the heck is an independent historian???	An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.

I apologize if I missed this. What are some of the things that can get a 99215 in some of the common visits? For example a teenager with chronic abd pain who seeds a workup but also anxiety as a considerable factor?	You still need to get there on 2/3 Components: problems addressed, data reviewed and risk. For problems addressed: there has to be a threat to bodily function or severe exacerbation. Unless the child is ill enough to consider hospitalization or has thoughts of self harm as part of their anxiety, the problems are going to be hard to get to a level 5. Same with risk: unless you are thinking about hospitalization, your chronic abdominal pain with anxiety doesn't give you a level 5 for risk either. For time, you would need 40 minutes of same day clinical work.
If you contact a specialist the following day, I know it won't count for time but how does it add to the MDM and should that be put in an addendum, the unfinalized chart, or a message?	If you want to count it for MDM, I would at least attempt to place the outreach on the same day as the visit whenever possible somewhere in the note (using care coordination tab will allow OP to count it for you.) For example: "Placed call to GI and left message with office to have them call me back. Will determine any change to treatment plan after discussing lab results with them." THEN when the GI person calls back, put it either in the messages or an addendum to the visit (if you get audited, be sure to include that informaiton with our note if asked for records.)
Not to be difficult, Sue, but if you advise a teenager about how careful he has tobe and avoid spreading to his GM because it will be a hard thing to live with the rest of his life, does that add to risk?	That's an interesting question and one I would suggest contacting the coding hotline with.
Can I include the time spent writing a referral letter (on the same day as the visit) toward total time?	See Slide 32 "What About Referrals" It's not the referral itself that will give you credit. If you write it in the note that increases your risk of your care for your patient.
We noticed that OP is counting in house labs toward data points in the suggested level of MDM. Will this be addressed/corrected so that practitioners do not accidentally up code based on the OP prompt?	This is corrected in version 20.11.3 & Version 20.11.5
Can pending be added? Scheduled medications remain pending for some time after sending and would help for these to automatically count.	This is in the works.
If in house test rule is overturned, will this be a retroactive effect to 1/1/21?	Cannot comment on this as it would be determined by the AMA and Insurance Payers.
Does it matter if MA or MD chooses the independent historian in the drop down? Do we get credit in OP if the MA does this drop down for us?	Anyone can add the Independent Historian. OP does not track who does it. Yes, but when in doubt spell it out. For example: For older children who may be capable of being their own historian, it is likely best to document somethig in the note supporting your coding choice. As the Provider document this information. The MA would not know if this is relevant.