Same or Similar Diagnoses for Follow-Up Visits

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Q. Is there a global period for the diagnosis used for follow-up on an evaluation and management (E/M) code when there is not a change in the chief symptom? We had a patient with a skin irritation for which the provider prescribed a hydrocortisone cream for the diagnosis of "dermatitis, unspecified" (L30.9). The provider instructed the patient to return in 1 week if the condition did not clear up. The patient returned 3 days later when the condition had not completely cleared. The provider inspected the skin, stated that the skin was healing well, and told the patient to continue using the cream. What does the urgent care center bill for this recheck on the original condition?

A. There is no limit or global period established for using the same diagnosis code in regard to follow-up visits where only the E/M code was billed initially and there was no surgical procedure performed where global periods apply.

The *Medicare Learning Network for Evaluation and Management Services Guide*[1] states, "For presenting problem with an established diagnosis, the record should reflect whether the problem is

- Improved, well controlled, resolving, or resolved
  or
- Inadequately controlled, worsening, or failing to change as expected"

Unless the patient is rechecking within the specific global period for a previously billed *Current Procedural Terminology* (CPT) code, an E/M code should be used if the provider documents the medical history, physical examination, and medical decision-making. As long as your documentation meets the required components for assigning an E/M code, you can bill that E/M code with the ICD-10 (*International Classification of Diseases, 10th Revision, Clinical Modification*) codes, whether or not those same ICD-10 codes were coded in a recent visit.

"The provider instructed the patient to return in 1 week if the condition did not clear up. The patient returned 3 days later when the condition had not completely cleared. . . . What does the urgent care center bill for this recheck on the original condition?"

The patient obviously had concerns that the rash had not cleared up. Documenting the location of the rash and the context in which the patient is presenting is considered, at minimum, a brief history of present illness (HPI). Just a question or two regarding the area where the rash is located and documenting the answer(s) suffice for the minimum requirement for the review of systems (ROS), and documenting one past medical, family, or social history (PFSH) item meets the minimum requirement for an established patient, resulting in a problem-focused medical history component.

Performing and documenting an examination of the area where the rash is located will suffice for a problem-focused examination, even if it is restricted to one body area or organ system.

The final and probably most important component of the E/M is the medical decision-making (MDM) component. There are two options listed under the number of diagnoses or treatment options for an established problem:

- Established problem stable or improved
- Established problem worsening

[1] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

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They both are assigned data points on the Marshfield Clinic audit tool. The other two areas under the MDM section are the "amount and/or complexity of data reviewed," which were not used in your scenario, and the "risk of complications, morbidity and/or mortality." Credit is given even for minor or self-limited problems. These three areas of MDM together would merit assigning a decision-making level of "straightforward complexity of MDM" at a minimum.

If you performed and documented the very minimum requirement for each component of the E/M, you would have a problem-focused medical history, a problem-focused examination, and a straightforward MDM. Thus, with minimum (but appropriate) documentation, you could code at least a level 2 office visit (99212) for the encounter. Use the same diagnosis code (L30.9, "dermatitis, unspecified") because the diagnosis has not changed. ■

Q. Recently, a patient with stomach pains came to our urgent care clinic and was diagnosed with salmonellosis without having any laboratory tests performed. Several days later, the patient presented with diarrhea and bloody stool. A stool sample was sent to the laboratory, and tests revealed *Campylobacter*, requiring a new prescription. In addition to the laboratory tests, can a new E/M code be billed on the follow-up visit with the original chief presentation?

A. No. A new-patient E/M code would not be appropriate, because the patient is rechecking with a provider who had already provided face-to-face services to the patient within the last 3 years.

I do not believe that an accurate diagnosis of salmonellosis can be made without testing. However, in the unlikely case that a provider makes this unsupported diagnosis, this recheck would result in at least a level 2 office visit (99212) with just the minimum documentation for a problem-focused medical history and examination. The complexity of the MDM would be moderate because you are assigning a new diagnosis of A04.5 ("*Campylobacter* enteritis") for the "number of diagnoses or treatment options," and the laboratory test can be counted toward the "amount and/or complexity of data reviewed." The new prescription would constitute a moderate level of risk in the "risk of complications, morbidity and/or mortality" area. Therefore, with proper documentation of the medical history and physical examination for this ill patient, this new diagnosis would support a new E/M 99214 code. ■

Q. A patient visited our clinic twice recently. The patient reported restlessness due to anxiety, so our provider prescribed Ambien, for with insomnia. The patient returned for evaluation by the same provider for food poisoning (new chief symptom), but the provider saw in the medical history that Ambien was prescribed for insomnia. Ambien's adverse effects include stomachache and diarrhea, which the unaware patient mistook for food poisoning. Our provider pointed out the adverse effects and recommended that the patient cease taking Ambien. Can this follow-up on the same original diagnosis of insomnia be billed as a new E/M code?

"[A] second visit would not support a new-patient E/M code, because the patient is rechecking with a provider who had already provided face-to-face services to the patient within the last 3 years. . . . Diagnosis selections require that close attention be paid to the coding instructions for each of the categories."

A. The second visit would not support a new-patient E/M code, because the patient is rechecking with a provider who had already provided face-to-face services to the patient within the last 3 years. In this case, your diagnosis selections require that close attention be paid to the coding instructions for each of the categories.

Because the patient was found to be experiencing adverse effects from the Ambien, you would search for benzodiazepine in the ICD-10's table of drugs and would find ICD-10 code T42.4X5A, "adverse effect of benzodiazepines, initial encounter." The guidelines at the beginning of the section state to "code first, for adverse effects, the nature of the adverse effect. . . ." Because the patient presented with diarrhea caused by drugs, you search and find code K52.1, "toxic gastroenteritis and colitis." You will then be instructed that you must "code first (T51–T65) to identify toxic agent." Therefore, your primary diagnosis is T52.3X1A, "toxic effect of glycols, accidental, initial encounter." Your second diagnosis is K52.1, and your third diagnosis is T42.4X5A.

There was medical necessity with at least the very minimum of documentation required for a level 2 established-patient office visit (99212) and up to a level 4 established-patient office visit (99214), assuming that the physician documentation supported this level. ■