

Well Visit: Code and Finalize the Visit Note

Last Modified on 11/21/2022 8:49 am EST

Version 20.18


Path: Clinical, Practice Management, or Billing tab > Patient Chart button > Well Visits > New or Open Note button

Path: Clinical, Practice Management, or Billing tab > Schedule button > Calendar or Tracking radio button > Right-click appointment > Open Well Visit

About

Below are the steps a provider will take to code and finalize a patient's Well Visit.

Assessment: Review/Add Diagnosis Code(s)

1. Navigate to the Well Visit Note by following one of the paths above.
2. Click **Assessment** in the Window Navigation panel.
3. Review the diagnosis code(s) for the Visit in the Diagnoses section of the window, and add or modify, if necessary. To add or modify ICD-10 codes:
 - a. Enter the name or description in the **ICD-10 Description** field or the ICD-10 code in the **ICD-10** field.
 - b. Press **Enter** on your keyboard or click the **Search** button . The ICD window displays with the practice's Frequently Used list.
 - c. Choose the code, and click the **Select** button. If the code was not displayed in the Frequently Used list, click the **Full Search** button and select the **Complete** and **Master** radio buttons to expand the search and make your selection.
 - d. Repeat the above steps for any additional diagnosis codes.

Note: Select the checkbox in the **Add PL** column if the diagnosis should be added to the patient's Problem List. Click the **Yes** or **Yes + Details** to confirm.



- If you chose **Yes**, you are required to complete the entry in the Problem List at a later time.
- If you chose **Yes + Details**, the Problem List window opens to complete any additional information.

Coding: Code the Visit

1. From within the Well Visit Note, click **Coding** in the Window Navigation panel.
2. Verify the **Visit Type** is correct. The default is **Estab**. If coding for a new patient, select the appropriate radio button.
3. Click the **Use Suggested** button to apply the suggested E/M code.
4. If there were abnormal findings, select the **Abnormal Findings** checkbox.
5. Review the CPT Codes in the lower section of the Coding window.

Note: CPT codes associated with the applied template will show in the lower section of the window. Additional CPT codes can be added and will show in the visit note, but duplicated CPT codes will not pass to the electronic superbill. When appropriate, the units of a CPT Code can be modified on this window. If duplicated, CPT codes must be billed on separate claim lines, and your practice will need to develop a process for notifying your billers.



6. Add additional CPT codes, if necessary.
 - a. Click a **Category** button.

- b. Double-click a CPT code to select it. If the CPT code was not found in the Category, click the **Lookup CPT** button and select the **Complete** and **Master** radio buttons to expand the search and make your selection.
- c. Repeat the above steps for additional CPT codes.



Note: After all appropriate ICD-10 and CPT codes have been added to the visit, assign the diagnosis codes to the corresponding procedure (CPT) codes by clicking in the DX1, DX2 etc. fields and selecting the appropriate DX for each CPT.

7. *(Optional)* Select **Ready to Bill** from the Billing Status drop-down to indicate the visit is ready to be billed. This status is displayed on the Tracking Schedule.

Summary: Finalize the Note

1. From within the Well Visit Note, click **Summary** in the Window Navigation panel.
2. Review the Note.
3. *(Optional)* Create a Patient Exit Note to provide to the parent.
 - a. Click the **Patient Exit Note** tab.
 - b. Click the **Rebuild Summary** button.
 - c. Click the **Print Note** button to print.
4. *(Optional)* Modify the visibility of the note, click the **Note visibility** drop-down and select the visibility level from the list.
5. *(Optional)* Modify the note type, click the **Clinical Note Type** drop-down and select from the list. The Clinical Note Type will default to Progress Note.
6. *(Optional)* Complete the **Reviewed by** field. If the practice or state requires a percentage of Notes charted by mid-levels or medical students to be reviewed, and the reviewer is visible on a note, click the drop-down arrow and select the reviewer.
7. Click the **Finalize** button. The Confirmation dialog box is displayed.
8. Click the **OK** button to finalize or click the **Cancel** button if you are not prepared to finalize.



Note: In the Staff Provider directory window, if the **co-signature required** checkbox is selected for the user, then the Note is not locked down when the user finalizes the note. Notes can then be edited by the supervising provider. If the co-signature required is not selected in the Staff/Provider Directory window when the user finalizes the Note, then the Note will not appear on the supervisor's list to review.

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