

Encounter: Code and Finalize the Visit Note

Last Modified on 11/21/2022 8:48 am EST

Version 20.18


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

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

About

Below are the steps a Provider will take to code and finalize a patient's Encounter.

Assess/Plan: Review/Add Diagnoses, Assessment, Plan & Patient Instructions

1. Navigate to the Encounter Note by following one of the paths above.
2. Click **Assess/Plan** in the Window Navigation panel.
3. Review the diagnosis code(s) in the **Diagnoses** section of the window.
4. Review the **Problem Status** for each diagnosis. Click the drop-down to change, if needed.
5. *(Optional)* Add additional 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.

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.

6. Review the **Assessment** section of the Encounter, and make changes as needed.
7. Review the **Plan** section of the Encounter, and make changes as needed.
8. *(Optional)* Select the **Managing patient's medication** checkbox if the patient has a medication that is being managed. This counts towards Risk of Complications for the purpose of MDM-based E/M coding.
9. Review the **Patient Instructions** section of the Encounter, and make changes as needed.



Tip: If your Practice has selected the **global preference** to show the Template Name as a header in the Plan and Patient Instructions section of the note, you'll see it displayed after applying a Diagnosis Template. To remove this header, you can simply click into the text box and remove the text.

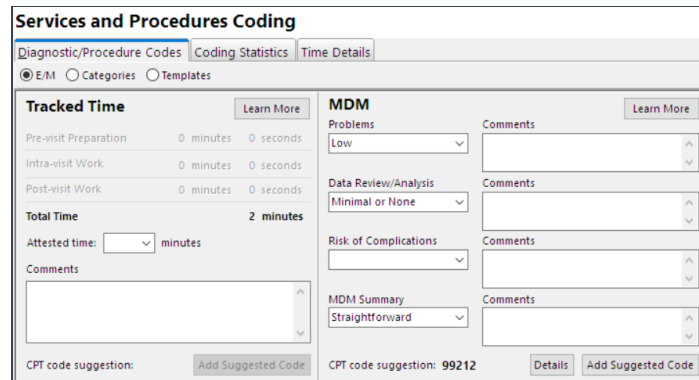
Coding: Code the Visit

1. From within the Encounter 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 **New pt** radio button.

Visit type: Estab New pt

3. Review the Tracked Time and MDM coding calculation information.

- In the Tracked Time section, the **Learn More** button can be used to navigate directly to the **Time-based Coding section of the OP Help Center**. For a more specific breakdown of the amount of time spent by the Rendering Provider in each of the time-tracked areas in OP, click the **Time Details** tab. The information in this tab is read-only and is grouped by category according to the Visit Status preference settings if made by the practice.
- In the MDM section, the **Learn More** button can be used to navigate directly to the **MDM-based Coding section of the OP Help Center**. The **Details** button can also be used to see how each section was calculated based on MDM elements documented.



The screenshot shows the 'Services and Procedures Coding' window with the 'Time Details' tab selected. The 'Tracked Time' section includes a 'Learn More' button, a table for Pre-visit Preparation, Intra-visit Work, and Post-visit Work (all showing 0 minutes and 0 seconds), a 'Total Time' of 2 minutes, an 'Attested time' field, and a 'Comments' field. The 'MDM' section includes a 'Learn More' button, dropdown menus for Problems (Low), Data Review/Analysis (Minimal or None), Risk of Complications, and MDM Summary (Straightforward), each with a corresponding 'Comments' field. At the bottom, there are 'CPT code suggestion' fields with 'Add Suggested Code' buttons.

Tip: In both methods of coding, all post-visit work done for an Encounter has the potential to alter suggested codes. There may be cases where a Provider will choose to delay Encounter coding and finalization.

4. Select the E/M code to apply to the visit following the steps below:

Code the Encounter using Time-Based E/M Coding	Code the Encounter using MDM-Based E/M Coding*
<p>If you <u>agree</u> with the Total Time displayed Click the Add Suggested Code button in the Tracked Time section of the window. This populates the Total Time in the Attested Time field and adds the suggested E/M code to the coding grid.</p> <p>If you <u>do not agree</u> with the Total Time displayed Manually enter the amount of time you spent on the Encounter in the Attested Time field, and enter a Comment supporting the change of Time. These comments are shown in the Encounter Summary. This repopulates a Suggested Code. To apply the newly suggested code, click the Add Suggested Code button.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Note: Comments entered only appear on the Encounter Summary when the Add Suggested Code is selected. If comments are entered and you do not choose the Add Suggested Code but manually add a code, these comments will not appear on the Encounter Summary.</p> </div>	<p>If you <u>agree</u> with the element levels displayed Click the Add Suggested Code button in the MDM section of the window. This adds the suggested E/M code to the coding grid.</p> <p>If you <u>do not agree</u> with the element levels displayed Refer to the Details button, and if appropriate, revisit and complete the sections of the Encounter that determine element level. Or, manually select the level you feel is appropriate and enter a supporting comment in the respective Comments field(s). These comments are shown in the Encounter Summary.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Warning: If you use the drop-down(s) to manually make a selection and then leave the Coding section of the Note, the selections are reverted to what the documentation supports.</p> </div>
<p><i>*Regardless of the coding method used for the Encounter, it is recommended to document the method, Time or MDM, in the Note in case it is ever called into question during an audit.</i></p>	

5. Review the CPT Codes in the coding grid located 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, using one of the following methods:
 - Enter the CPT code in the **Add CPT Code** field, and press Enter on your keyboard to add it to the coding grid.
 - Click the **ellipsis** to search for and select a CPT code. Remember to change the search options to select the **Complete** and **Master** radio buttons to conduct the most thorough search.
 - Select the **Categories** radio button, choose a category, and double-click the code to apply it.
7. After all 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.
8. *(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 Visit Note, click **Summary** in the Window Navigation panel and review the Encounter note.
2. *(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.
3. *(Optional)* Modify the visibility of the note, click the **Note visibility** drop-down and select the visibility level from the list.
4. *(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.
5. *(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.
6. Click the **Finalize** button. The Confirmation dialog box is displayed.
7. 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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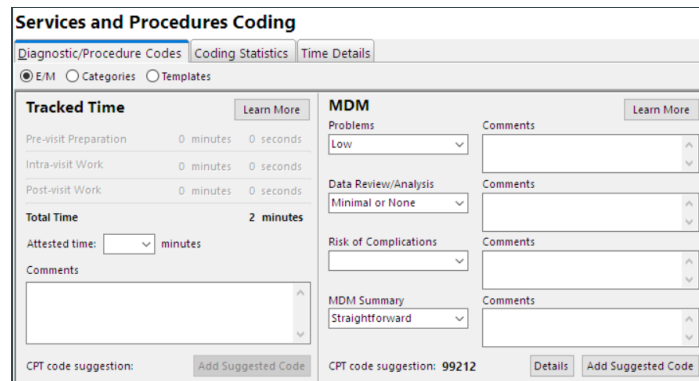
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