IDSA
Infectious Diseases Society of America

IDSA Evaluation and Management CPT Coding Guide

Frequently Asked Questions

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Q: I am seeing a patient in the hospital as new patient and I reviewed the hospital medical record notes from different specialties that are not in my group including hospitalist, cardiology, and pulmonary. Would this count as three (3) unique sources?

- A: These notes would only count as one (1) unique source since it is from the same hospital medical record.

Q: I went to the microbiology lab and reviewed the Gram stain on a culture. Can I count this as an independent interpretation of a test?

- A: No. An independent interpretation of test refers to when a physician independently interprets a test which has a customary report, and a Gram stain result does not have a "customary report" as provided by a physician.

Q: During my interview with my patient who is able to provide a good and accurate history the patient's spouse also added information. Can I count the patient's spouse as an independent historian?

- A: No. This does not meet the requirements for needing an independent historian as the patient is able to give a good and accurate history.

Q: My patient was initially in the ICU for sepsis due to Staphylococcus aureus bacteremia which was life threatening. My patient has since improved with the resolution of the sepsis and the patient has moved from the ICU to regular floor bed. Do I continue to bill to bill this as an acute illness with threat to life?

- A: No. The problem addressed is determined by the problem status on that date of encounter and since the patient is no longer septic and no longer with an acute illness with threat to life, then would bill with the appropriate problem status.

Q: I spoke with the patient's attending physician and updated the attending physician with my plan of care. Can I count that as discussion of management with a physician?

- A: No. Discussion of management with a physician is counted when that discussion is used in medical decision making.

Q: I spent a total time of 84 minutes with an inpatient consult of which the majority of the time was spent with reviewing the medical record through the EHR while I was in my office, but the medical decision making was determined to be moderate. Can I bill higher due to the time spent?

- A: Yes. Time is determined as total time on date of encounter, and it is summed of all activities related to patient care including medical record review. Total time includes face-to-face time and non-face-to-face time including time spent off of the unit doing patient care and evaluation.

Q: I am treating my patient with an antibiotic that requires intensive drug monitoring twice weekly for creatinine due to high risk of acute kidney injury. Do I bill the risk as high due to the drug requiring intensive monitoring due to toxicity with each encounter?

- A: No. You would bill using drug therapy requiring intensive monitoring for toxicity in the encounter during which it was considered and in this case during those encounters during which you are monitoring the creatinine.

Q: I reviewed CT scan of abdomen and pelvis in person with the radiologist regarding concerned findings. How do I count that for billing?

- A: This would satisfy category 3 “Discussion of management or test interpretation” for moderate or high MDM as long as you document that discussion and results affecting MDM. You can also use this time as part of total time if total time meets a higher E/M visit than MDM.

Q: It takes me 10 minutes to walk from the unit I am on to the microbiology lab to review slides. Can I count that time it takes me to walk to the microbiology lab?

- A: No. Travel time does not count in total time.