Internal Medicine Coding Alert

Reader Question: Combat E/M Downcoding

Question: An insurer downcodes E/M visits because the diagnoses don't support the service levels that I billed. But I coded these visits based on time, not E/M elements. How can I get paid for higher-level counseling visits?

Delaware Subscriber

Answer: Beyond documenting the time, you should also note the substance of the counseling and the care coordination. Remember that Medicare and private payers often don't find documenting time alone as sufficient to support an E/M code.

In addition, to document that a visit qualifies as a time-based visit, you should note TV/C (total visit/ counseling). This will show the payer that you spent the majority of the visit (more than 50 percent) counseling the patient and/or family. Plus, if an insurer downcodes a visit, your billing department will have documentation to appeal the decision.

Suppose a patient comes in for quarterly allergic rhinitis (477.9, Allergic rhinitis; cause unspecified) follow-up. The patient would like to consider allergy injections as an alternative to the current treatment, which includes oral histamines and nasal decongestants. The internist spends 15 minutes on the initial exam (99213, Office or other outpatient visit for the E/M of an established patient ... physicians typically spend 15 minutes face-to-face with the patient) and another 25 minutes discussing the pros and cons of immunotherapy (15 + 25 minutes = 40 minutes, which qualifies for 99215, ... physicians typically spend 40 minutes face-to-face with the patient).

Using the TV/C documentation tool, you should report 40/25, which represents 40 total-visit minutes and 25 counseling minutes.

If the payer downcodes the office visit due to the single established-problem follow-up diagnosis, you should submit the notes showing that you coded the visit based on time. Also, indicate the counseling topic, which is possible immunotherapy.