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BY AAPC

Internal Medicine Coding Alert

Reader Question: Using Time to Assess E/M Code

Question: If a patient comes in to see the internist but the physician only discusses whether the patient should have surgery, should I bill an E/M code? One of our long-time patients is thinking of having a hip replacement. She wanted to discuss this with our internist because she said she feels more comfortable with him and trusts him. There was no exam or history taken, just 35 minutes of discussion.

Utah Subscriber

Answer: The E/M codes are structured two ways. The first and most common way is to select the correct code based on the extent of the documentation of the history, examination and complexity of medical decision-making. A second coding method comes into play when 50 percent or more of the total visit time is spent in face-to-face counseling with the patient in an outpatient setting. When this occurs, as it did in your patients encounter, time becomes the mechanism for code selection. Within the description of each CPT code is the time factor that is used for code selection when time becomes the controlling factor.

For instance, in the CPT manual, the description of 99214 states that the typical time for the encounter is 25 minutes face-to-face with the patient and/or family. The description of 99215 indicates a typical time of 40 minutes face-to-face with the patient and/or family. Thus, in your encounter, a 99214, a level-four visit, should be billed based on the fact that 50 percent or more (in your case, 100 percent of the visit) was spent in counseling with the patient. Although your encounter exceeds the typical time for a level-four visit by 10 minutes, it still is not enough to meet the time factor of a level-five visit (40 minutes). When billing E/M codes based on time, the physician must document in the medical record the total time of the visit, the amount of time spent in counseling, and a description of what was discussed.

The inpatient E/M codes (99221-99233) also have time factors, but instead of requiring that only face-to-face time in the inpatient setting with the patient be counted, time spent on the patients floor or unit in conference or coordinating care may also be counted toward the time element of these codes.

Answers for You Be the Coder and Reader Questions were reviewed by **Linda Bishop, CPC, CCS,** corporate compliance officer, Pediatric Management Group at Childrens Hospital, Los Angeles; and **Kathy Pride, CPC, CCS-P,** HIM applications specialist with QuadraMed, a national healthcare information technology and consulting firm based in San Rafael, Calif.

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