Part B Insider (Multispecialty) Coding Alert

COUNSELING: Document All Services Performed In Counseling Visit

If you don't hear back from the CERT contractor, you're probably in the clear

It's not just discharge management that requires documentation of time (see story, earlier in this issue). You also need to document time carefully if you're billing for counseling and coordination of care.

If a visit is more than 50 percent counseling and coordination of care, you can determine the level based on the time spent, instead of history, physical exam and medical decision-making (MDM). But you should still document any history, exam and MDM that happened in the visit, HGS Administrators clarified in a frequently asked questions (FAQ) item posted Dec. 21.

For a counseling and coordination of care visit, "time may be considered as the controlling factor to qualify for a particular level of evaluation and management (E/M) service," HGSA writes. But you should still document the history, exam and MDM in addition to the total amount of time spent with the patient and a notation that counseling and coordination of care accounted for more than half that time, HGSA says.

"If this FAQ is an accurate representation of the carrier's medical review department, then how will a physician bill for those post-diagnostic workup visits?" worries **Jean Acevedo** with **Acevedo Consulting** in Delray Beach, FL.

In those visits, the physician may explain the results, answer questions and go over treatment options, but there may not be any history or exam. Those visits are still valuable and medically necessary, so Acevedo believes HGSA's answer may have misstated the carrier's position.

"I think that the intent of this answer is to remind providers to document history and exam as well as time when both are performed," says Marcella Bucknam, coding manager for the **University of Washington's** physician group in Seattle. But the FAQ item "will certainly cause confusion for those circumstances when no history and exam are performed." Some practices may think they must document history, exam and MDM, even when none happened.

Document All Services Clearly

You should definitely document any history, exam and MDM (HEM) in the visit to help the carrier understand how much time the doctor spent on them, says **Laureen Jandroep, CEO** of the **CRN Institute** in Absecon, NJ. It makes it easier for the carrier to determine the percentage of time spent on counseling and coordination of care if you include everything that happened in the visit.

"The primary reasons we document in the medical record is communication and risk management," says **Cindy Parman,** co-owner of **Coding Strategies** in Powder Springs, GA. "The physician should always document all services provided to the patient, not just the time spent."

In most E/M visits, there will be some history, exam and MDM, says **Barbara Cobuzzi**, president of **CRN Healthcare Solutions** in Tinton Falls, NJ. For example: A patient just got back a malignant biopsy and spent 25 minutes with the physician. Out of that time, the patient spent 20 minutes discussing the prognosis of the biopsy, and the pros and cons of surgical and non-surgical options. That visit would include a little history of the biopsy and result, and the MDM consists of the doctor telling the patient to weigh the options before coming back for a follow-up visit.

More FAQs

Other recent FAQs from HGSA clarify important topics, including:

• If you submit documentation to the Comprehensive Error Rate Testing (CERT) contractor and don't hear anything for a few months, it probably means your claims didn't have any errors. "If an error was identified, HGSA would have adjusted the claim and contacted you to request a refund of any overpayments made," HGSA writes.

This is only good advice if you've already been paid. If you haven't gotten paid yet, then no news is definitely not good news, notes **Quinten Buechner** with **ProActive Consulting** in Cumberland, WI.

• Independent contractors can bill "incident to," but they must still be an employee of the physician with a 1099 form, and the physician must supervise the contractor, Cobuzzi says. The contractor can also be contracted with the same group that employs the physician, says Bucknam.

• A physician can prove "incident to" supervision by signing the medical record at the time of the visit. This isn't a requirement, notes Cobuzzi.

Just having the physician's signature won't prove the physician was there at the time the service was provided, note experts. If the physician's personal calendar or operative log show she was elsewhere, then the signature won't help, notes Bucknam.