# Part B Insider (Multispecialty) Coding Alert

## E/M Coding: Heed This Expert Insight to Correctly Code for Time

**Compare these auditor red flags with your practice's processes.**

Even for the most seasoned coders, determining the level of an evaluation and management (E/M) encounter using total time consistently can be confusing. Plus, your Part B practice may still be working out the claims issues in relation to using the 2021 updates to the CPT® Office and Other Outpatient Services codes. And now, these E/M rules are about to extend to hospital and inpatient E/M services, so there's no better time to clear up the confusion.

There are some misconceptions floating around that can wreak auditing havoc, and **Rae Jimenez, CPC, CDEO, CIC, CPB, CPMA, CPPM, CCS**, senior vice president of products at AAPC, cleared many of them up in "Risk Associated with Coding Time," her recent presentation at HEALTHCON Regional 2022 in Denver.

**Review the Activities That Can Count Toward Time**

Per the 2021 CPT® guidelines, the full list of activities that you can use to count time includes:

- "Preparing to see the patient (eg, review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)."

"One of the most common misconceptions on reporting an E/M based on time is that a provider is required to document the time spent on each specific task associated with the visit," says **Donna Walaszek, CCS-P**, billing manager, credentialing/ coding specialist for Northampton Area Pediatrics LLP in Northampton, Massachusetts. Instead, the provider needs to document the total time personally spent on the above-listed activities on the date of the encounter.

Here are four issues that auditors see as time-related red flags.

**Red Flag 1: Rounding Up the Total Time**

Rounding up will surely raise red flags to an auditor. Rounding up a few minutes on each encounter, turning 16 minutes into 20, or 25 into 30, may not seem like a big deal, but it can be. Plus, "... you don't want the time to look the same for every single patient," said Jimenez.

Think about it this way: When physicians round up on every patient, it has a dramatic effect by the end of the day. Adding an extra five minutes to each patient could end up looking like each physician spent hours longer at the clinic than they really did. Inflating time, whether intentional or not, is not best practice - in fact, compliance enforcement could consider it abuse or fraud, both serious and costly.

**Red Flag 2: Counting Ancillary Staff Time**

Per 2022 CPT® E/M guidelines, if a physician and other qualified healthcare professional (QHP), such as a nurse practitioner (NP) or physician assistant (PA), shared or split the time assessing and managing the patient on the date of the encounter, that time is summed to define total time. However, only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

For example, if a patient comes in for a follow-up and sees an NP, that NP is going to start to evaluate any new patient complaints. The patient may then consult with your physician about the problem and a new treatment plan. "The time

they spent in the room together is going to count only once. So, if the nurse practitioner spent 10 minutes with the patient, then invites the physician in and they spend 15 more minutes together, it's going to be a total of 25," said Jimenez.

**Red Flag 3: Not Documenting Services Performed Out of the Office**

Documenting time correctly is not only best practice - it often counts in favor of the physician. "The AMA defines time for E/M coding as the total time (based on minutes) the provider spends on the date of service during which a provider personally rendered services related to the patient's care, even if the times are not consecutive," explains Walaszek. Sometimes physicians forget to document all their time.

If those forgotten services are accounted for in the record and performed on the date of the encounter (for example, reviewing labs after the encounter on the same date of service [DOS]), you can justify that time if an auditor questions it. As noted above though, be careful not to double count time if the physician and a QHP spend time discussing a problem outside of the room after the encounter.

**Red Flag 4: Misrepresenting Other Billable Services**

There may be time your provider is spending that you may be missing. This could be the case when your provider documents how many minutes they spent with the patient, but they don't include the time spent preparing to see them. This is common for physicians who are still accustomed to documenting in-office visits based only on face-to-face time.

On the other hand, sometimes practices mistakenly count services twice. For example, for many minor surgeries, the CPT® code for the procedure includes time for pre-procedure evaluation, so counting that time toward time used to report an E/M code would be double counting and result in the physician getting paid twice for the same time. Pay close attention to which procedure codes include pre-procedure E/M. Also, pay close attention to the documentation. "If the physician is performing other billable services, add a note that says, 'total time is 20 minutes excluding other billable services,' so that in an audit there is no question," said Jimenez.

**Takeaway: Don't Be Afraid of Time-Based Leveling**

Using time to level an encounter is not only perfectly legitimate, it's also often in the physician's best interest to code this way. The documentation must be precise, though, to justify the time spent. When auditors perform time-based

audits, "they will look at your schedule for the day and see how much time was worked, then total up all your visits. If you coded based on time and those hours add up to 20, but the actual hours worked was only 10, that doesn't add up," said Jimenez.

Fixing these issues before they become bigger issues might be a matter of more precise time reporting. Rounding up, forgetting to document same-day non-face-to-face time, and misrepresenting other billable services will all lead to inconsistencies during an audit. The best thing to do is study the patterns of the practice to see if there are any anomalies. As always, be sure to keep an open line of communication between your coding department and your physicians.