Part B Insider (Multispecialty) Coding Alert

E/M Coding: Yes, You Can Report E/M Codes When Talking to Family About Patient Care

As long as the patient is present, CMS allows you to bill an E/M code based on time.

It happens frequently in Part B practices□a patient presents with her family members, who want to discuss how to care for the patient's condition. The doctor spends most of his time discussing care with the family rather than the patient, leaving coders to wonder how to report the service□should you bill a counseling code, an E/M code, or some other combination? Fortunately, if you can document time-based services, then you are on the road to reporting family visits when the patient is present.

Watch the Clock

Your best bet when discussing care with a patient and her family is to bill an E/M service (99201-99215) based on time. Because the doctor is performing counseling based on an active condition that the patient has, you are justified in reporting the appropriate E/M code based on the amount of time spent performing face-to-face counseling or coordinating care.

When you're billing based on time, CPT® defines "face-to-face time" as "only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient." Because CPT® uses the language "with the patient and/or family," it's clear that you can discuss the care with the patient's family and not just with the patient to count it toward the time-based E/M code.

Medicare says: When counseling and/or coordination of care dominates (more than 50 percent) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time may be considered the key or controlling factor to qualify for a particular level of E/M services.

If you are selecting a code based on time, the medical record should show three pieces of information, says Part B MAC WPS Medicare in its "Time-Based E/M Services" Fact Sheet. "The total time of the visit, the time or percentage of the visit spent in counseling/coordination of care and the nature of the counseling/coordination of care. When the physician uses the total minutes or the clock time is a personal decision. Medicare needs to be able to see the three pieces of documentation as listed above."

Consider These Examples

Several scenarios below serve to illustrate different options applicable to counseling coding and documentation.

Example 1: A 78-year-old established male patient with Alzheimer's presents to your practice with her son and daughter-in-law. The doctor counsels them about how to deal with the illness and how to administer appropriate medications. The face-to-face encounter takes 45 minutes, 35 minutes of which is spent counseling the patient, her son and her daughter-in-law.

Coding Solution: For this visit, you can report 99215 (Office or other outpatient visit for the evaluation and management of an established patient ... Typically, 40 minutes are spent face-to-face with the patient and/or family) based on the amount of time spent with the patient in counseling/coordination of care, assuming your documentation meets the guidelines (see below).

Example 2: A 75-year-old male patient is hospitalized with a heart attack. His cardiologist meets with the patient and his wife to counsel them on the risks and benefits of different kinds of treatment, including angioplasty. Although the doctor only spent 20 minutes with the patient prior to the wife entering the hospital room, he spent 20 minutes in discussion with her, for a total of 40 minutes. He was at the patient's bedside the entire time.

Coding Solution: If the patient is in the hospital and the family comes into the room to talk with the doctor, you can count that toward the total visit time. In this case, use code 99233 (Subsequent hospital care, per day, for the evaluation and management of a patient...Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit).

Ensure Crystal Clear Documentation

Before using time as the controlling factor, check off the following requirements that must be documented based on CMS guidelines

1. The total time spent with the patient
2. That more than 50 percent of the face-to-face time the physician spent with the patient/and or family is counseling/coordination of care. For instance, "Saw the patient, her daughter and her son-in-law for 30 minutes face-to-face; 25 minutes of that visit was spent in counseling concerning ...."
3. A description or summary of the counseling/coordination of care provided. For Example One above, you could consider, "Counseled the patient and her family to address coping strategies for the patient's diagnosis of Alzheimer's disease and treatment options."

What If the Patient Isn't Present?

If the patient's children or spouse present to the practice to discuss the patient's condition with the doctor and the patient is not present, you cannot bill Medicare using the E/M codes. Although CPT® rules support reporting the E/M codes without the patient present, CMS sings a different tune. "CMS states that the patient has to be present," says Coding Consultant Donelle Holle, RN.

Red flag: Provider documentation such as "I had a lengthy discussion..." or "I spent a great deal of time with the patient discussing..." does not support using the dominant counseling/coordination of care as the basis for level of E/M service. You should only select an office visit code based on time when your clinician spends more than 50 percent of the face-to-face time with the patient and/or family member on counseling and/or coordination of care.

Key: Medical necessity must also be a key factor in your code choice. Be sure that the time spent with the patient or her family is warranted. Just because the patient and provider talked for a long time doesn't mean it was medically necessary to do so.