Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: 'I Spent An Hour With the Patient' Won't Hold up Unless It's in the Record

Check out this case study and figure out why it doesn't qualify for time-based coding.

Medical record auditors hear it nearly every day from practitioners: "You can't downcode my claim! I spent an hour with that patient, so I know I deserve a 99215." But a physician's memory won't hold up in court only documentation will do so.

Background: When medical auditors review E/M claims, they typically code the reports based on history, exam, and medical decision-making, unless the physician meets the criteria to code a claim based on time spent with the patient. However, full-time auditors tell the Insider that they hear from physicians at least once a day who argue that, although their documentation may not support 99214s and 99215s, the codes are justified based on the fact that the patient had questions and counseling took up an hour of their time.

Myth: The physician's argument that he spent a significant amount of time counseling the patient justifies high-level codes.

Reality: The physician's memory may be pristine, but it can't be relied upon if the payer asks for a refund due to insufficient documentation. Instead, the doctor must note the time spent in the record.

Case in point: See if you can spot the problem with this chart entry:

A 72-year-old patient seen for COPD (chief complaint) FU visit. She has been on inhalant medication (HPI-modifying factor) for one month (HPI-duration) but is not doing well (HPI-quality). She is still having problems breathing, especially while walking in the city, where she lives (social history-living arrangements) and with having difficulty when she leans back or lies down and then feels short of breath instantly (HPI-severity). Her sons have also noted problems with appetite (ROS-constitutional) and sleep issues (ROS-neurological or respiratory-not both). Physical examination consists of a brief respiratory examination (can't give credit here as there are no details). Extensive **counseling** is done, discussing additional ways she can use a pillow to prop herself up when she rests to decrease her symptoms, and also to talk about ways to combat breathing problems when walking in the city (suggested a mask and told her the pros and cons of oxygen and when it's likely that she may need to use it) (counseling description). Her inhalant dosage is increased (prescription drug management-table of risk-moderate) (MDM risk: 2 pts) and FU planned in one month. Total face-to-face time is 25 minutes.

Did you spot it? The problem with this record is that you can't use the 25 minutes of time spent without knowing how much of that time was spent counseling.

Step 1: Include 3 Items in Documentation

Before using time as the controlling factor, check off the following requirements that must be documented:

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 for 25 minutes face-to-face; 20 minutes of that visit was spent in counseling."

3. a description or summary of the counseling/coordination of care provided. For the example above, you could consider,

"Done to address coping strategies for the patient's diagnosis of COPD and treatment options."

CPT lets you select an office visit code based on time only when the physician 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.

Step 2: Use Elements When Time is Unknown

In this case, because the time spent in counseling/coordinating care is unknown, you instead have to code the visit based on the documented history, exam, and medical decision-making, as follows:

History: Detailed

HPI-quality, severity, duration, modifying factors-Extended

ROS: One element: Constitutional, Neuro (or respiratory-not both)

PFSH-Social: 1 element

Exam:

None that can be used in counting the elements.

Medical Decision-Making: Low

Est. Problem worsening-2 points

Data-None

Risk-Problem worsening

CODE: 99213 (History-Detailed and MDM-Low complexity).

Without knowing how much of the 25 minutes the physician spent counseling, the key documented elements support 99213, not 99214.

Solution: Adding the actual time that the doctor spent on counseling would indicate that the encounter meets time-based coding's greater than 50 percent on counseling/and or coordination of care criteria and would therefore justify a 99214 for this case.