Part B Insider (Multispecialty) Coding Alert

READER QUESTION: Counseling/Coordination Domination? Consider Time-Based Billing

Question: An established pregnant atient with a plan of care in place for her gastroesophageal reflux disease reports to the gastroenterologist complaining of severe morning sickness and throat pain. Notes indicate a level two E/M level: however, total encounter time was 31 minutes, and the gastroenterologist spent 20 of those minutes discussing medication options and diet, and helping the patient arrange a visit with her obgyn. Can I code this visit based on time?

Answer: Based on your description, you should be able to report an E/M code based on total encounter time. On the claim, you'll likely report 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity ... Physicians typically spend 25 minutes face-to-face with the patient and/or family) for the E/M.

Remember to append 530.81 (Other specified disorders of esophagus; esophageal reflux) and V22.2 (Pregnant state, incidental) to 99214 to represent the patient's symptoms and pregnancy, respectively.

Warning: You can only code based on total encounter time in very specific situations. If more than half of the total E/M time is spent on counseling and coordination of care, then you can base coding on encounter minutes. CPT considers discussion of the following topics covered by its counseling umbrella:

• diagnostic results, impressions and/or recommended diagnostic studies

• prognosis

• risks and benefits of management (treatment) options

• instructions for management (treatment) and/or follow-up

• importance of compliance with chosen management (treatment) options

• risk factor reduction

• patient and family education.

Any encounter time not spent on the above topics cannot be considered counseling. Lend credence to your time-based E/Ms by including documentation that specifies exactly what the astroenterologist discussed during the patient encounter -- and for how long.