Eli's Rehab Report

3 Steps to Base Your E/M Visit On Time With Patient

Long E/M visits and time spent reassuring and counseling patients in the office does not have to go under-reimbursed, if you know the E/M ropes.

Time rather than the key E/M components of history, exam and medical decision-making (MDM) can be the determining factor when choosing an E/M service level, thereby allowing the physiatrist to report a higher-level code than the key components alone would actually warrant.

Step One: Know the Requirements

According to CPT guidelines, when counseling or coordination of care dominates the physician/patient encounter (that is, it comprises more than 50 percent of the visit), "time may be considered the key or controlling factor to qualify for a particular level of E/M services."

Counseling and coordination of care may include discussing one or more of the following areas with the patient: diagnostic results, impressions and/or recommended diagnostic studies, prognosis, risks and benefits of treatment options, instructions for treatment and/or follow-up, importance of compliance with chosen treatment options, risk factor reduction, and patient/family education, according to the January 1998 CPT Assistant.

Suppose an established patient with a history of transient ischemic attack (TIA, 435.9) presents to your PM&R practice complaining of neck pain. The physiatrist examines the patient for 15 minutes and determines that the pain is actually based in the patient's neck muscles, and stems from picking up her grandchildren, who recently visited her. The physician's exam documentation demonstrates that the correct code for the visit is 99213.

Suppose the patient is anxious and extremely concerned about the possibility of another TIA because her prior TIA began with neck pain symptoms. The physiatrist spends 25 minutes discussing the reasons that he believes the pain is based in the patient's neck muscles, possible signs to look for when TIA is suspected, exercises that can help the patient strengthen her upper body, and instruction on how to pick up heavy objects without straining her muscles. Because counseling and coordination of care dominated the encounter, you can use time as the controlling factor when assigning the E/M service level.

Consult Standard E/M Reference Times

To determine the appropriate E/M level for the time spent with the patient, you must check the reference time included in the CPT descriptor for each code, says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS**, director and senior instructor for the CRN Institute, an online coding certification training center based in Absecon, N.J. For instance, the descriptor for 99213 (Office or other outpatient visit for the evaluation and management of an established patient ...) states, "Physicians typically spend 15 minutes face-to-face with the patient and/or family."

Remember that to justify a given level of E/M service, the physician must spend over half the total time on counseling or coordination of care. Therefore, if the physiatrist documents spending 25 of a 40-minute visit on counseling, he or she should upgrade the visit to a 99214.

Counseling time also includes time that the physician spends with the parties who have assumed responsibility for the patient's care or decision-making. But remember, Medicare and most insurance companies do not pay for family education if the patient is not present. If a family member wants to talk to the physiatrist concerning a patient's upcoming nerve conduction study, for example, Medicare requires the patient to be present in the room with the family

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member.

Note: The time the physician spends taking the patient's history or performing an examination does not count as counseling time. The physician must look at the entire patient encounter and decide if he or she spent the majority of time in counseling and coordination of care or if the key components of history, physical exam and MDM should be the deciding factor when choosing an E/M level.

Step Two: Document Your Work

Documentation is crucial for time-based E/M services. Ideally, the physician should specifically note start and stop times for the patient visit, as well as the portion of the time spent on counseling and coordination of care, Jandroep says. CMS guidelines require that physicians document exact times, and they may have trouble during an audit if they have not noted this information.

And, physicians should document what issues they discussed in counseling (for example, treatment options and prognoses). The physician might note, "25 minutes with patient discussing the role of exercise in alleviating muscle pain, differences between muscle pain symptoms and TIA warning signs," etc.

The physiatrist should include the components of history, exam and MDM in the documentation. Good medical recordkeeping requires you to document relevant and pertinent information, and using time as the determining factor to choose the E/M level does not negate this requirement.

Step 3: Perform a Self-Test

To ensure that you can ethically report your E/M visit based on time spent counseling the patient, take this self-test, says **Mary Falbo, MBA, CPC**, president of Millennium Healthcare Consulting Inc. of Lansdale, Pa.

1. Does the documentation include the total face-to-face time in the outpatient setting or on the unit/floor in the inpatient setting?

2. Does the documentation describe the content of the counseling or coordination of care?

3. Does the documentation indicate that the physician spent more than half of the time counseling or coordinating care?

If you answer "Yes" to all of these questions, feel confident basing your E/M level selection on the time spent counseling the patient.

For more guidance, see our article "Set Up a Template for Time Guidelines."

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