Eli's Rehab Report

Maximize Reimbursement With This Vital E/M Documentation

Hint: Minutes equal money for physiatry E/M coding

If you're forgetting about coding by time for your physiatrist's counseling services, you could be missing out on money your practice ethically deserves.

Learn This Little-Known Fact

You can code an E/M service based on time when the physician spends more than 50 percent of his face-to-face time with the patient providing counseling and/or coordinating care.

CPT states if counseling and/or coordination of care constitutes more than 50 percent of the physician/patient encounter, you may use time as "the key controlling factor to qualify for a particular level of E/M services." CPT also stresses that to code by time the physician must clearly document the extent of counseling and the time involved.

The basics: For most E/M codes, **CPT lists** the time the physiatrist usually spends rendering the service. For example, for established patient code 99214, CPT states, "Physicians typically spend 25 minutes face-to-face with the patient and/or family." This is called the "reference time."

How to use the reference time: Suppose your physician completes an expanded problem-focused history and examination on an established patient (enough for a level-three visit), but spends a total of 25 minutes with the patient and documents that he spent 18 of those minutes providing counseling. Because more than 50 percent of the visit consists of counseling, you can use the total time to determine the level of service. In this case, you could report 99214 - which pays about $35 more than 99213.

Document and Verify All Times Involved

The most important part of coding by time is having complete and adequate documentation of the visit - including documentation of the total visit time and the total time the physician spends counseling, says **Lynn M. Anderanin, CPC,** director of coding and appeals at Healthcare Information Services in Des Plaines, Ill.

If you want to be able to code based on time, make sure your physicians know to document the following:

1. Beginning and end time of the counseling and/or coordination of care. This information is crucial for determining if the counseling accounted for more than 50 percent of the visit.

2. Beginning and end time of the overall face-to-face visit. "I've actually gotten some of my physicians in the habit of writing the time they go into a room and writing the time they step out of the room - and that often helps us support that 50 percent of the visit or more was spent on counseling," says **Jaime Darling**, **CPC,** a certified coder with Graybill Medical Group in Escondido, Calif.

3. Details about the counseling session's content. Auditors may consider a claim fraudulent if you coded by time but your physician only documented "spent time counseling." The physician should provide a summary of what the counseling or coordination of care involved, Darling says.

Counseling may involve services such as disease pathology, anatomy and mechanism of injury, discussion of test results and prognosis, instructions and/or education for self-care or medication, and planning for future services, says **Judy Richardson, MSA, RN, CCS-P**, senior consultant with Hill & Associates in Wilmington, N.C.

Next, calculate: If your physician provides all the necessary time documentation, you then need to calculate the total visit minutes and total counseling minutes to prove that counseling dominated the visit.

Play it safe: If your physician does not include enough documentation about counseling and/or coordination of care during the patient's visit, you may have no choice but to code a lower-level E/M service.

Be careful what you count as "counseling": Time spent taking the patient's history or performing an examination does not count as counseling time.

Take Advantage of 2 Main Benefits

CPT's code-by-time catch may allow you to justify a higher-level E/M code or to report a visit that lacks one of the required key components (history, exam and medical decision-making, or MDM) if counseling dominates the visit, Darling says.

Higher level of service: For example, a new patient presents to your practice with a chief complaint of neck pain (723.1, Cervicalgia) following an automobile accident. She brings along copies of all radiology films. The patient's case manager is in attendance at the visit. The physiatrist, patient, and case manager spend 45 minutes of the 60-minute visit discussing the anatomy and mechanism of injury, diagnostic test results, and both preventive measures and treatment options to alleviate symptoms.

In this case you may report 99205 (Office or other outpatient visit for the evaluation and management of a new patient ...), which has a reference time of 60 minutes, because at least 50 percent of the visit involved counseling and/or coordination of care.

Visit lacking one required key component: Physicians often spend time-consuming visits coordinating care for patients, but they don't always document an adequate history or exam. Even if one or more of the required components is completely missing from the visit, the CPT guidelines indicate that "you can still code for the visit based on time as long as the physician spends 50 percent or more of his time counseling the patient," Darling says.

For example, the physiatrist meets with an established patient to review the results of recent needle electromyography/nerve conduction studies. The physiatrist takes a problem-focused history but performs no physical exam. The documentation indicates a 25-minute total visit time, and the physician devotes 20 of those minutes to counseling the patient and coordinating the patient's plan of care. If you code by time for the visit, it qualifies for a level-four patient visit - 99214.

Editor's note: For a free pocket E/M guide, e-mail me at suzannel@eliresearch.com.