Eli's Rehab Report

Reader Questions: Document the Time Spent on Counseling

Question: One of our insurers downcodes my E/M visits because the diagnoses don't support the service levels that I billed. But I coded these visits based on time, not E/M elements. How can I get paid for higher-level counseling visits?

Virginia Subscriber

Answer: To prove that a visit qualifies for time-based E/M billing, make sure the documentation includes the ratio of the total visit time to the counseling time. This will show the payer that you spent most of the visit (more than 50 percent) counseling the patient and/or his family.

Example: A 26-year-old patient recovering from a closed head injury due to an automobile accident presents for a follow-up visit. The physiatrist discharged him 10 days ago from an acute rehabilitation hospital. The patient's wife and insurance nurse case manager attend with the patient for this visit.

The physiatrist performs the key components of problem-focused history, expanded problem-focused exam, and moderate decision-making to meet a level-three established patient office visit (99213, Office or other outpatient visit for the evaluation and management of an established patient ... physicians typically spend 15 minutes face-to-face with the patient).

However, the provider spends 35 minutes of the 48-minute visit in counseling. The provider specifically documents in the visit note that he spent "35 minutes of the 48-minute visit in counseling with the patient, the patient's spouse and nurse case manager regarding treatment and management options for his cognitive deficits and short-term memory impairment."

"The discussion included the importance of establishing daily routines and compliance in medication management, a behavioral outpatient training program for the patient, potential speech outpatient therapy, and support services in the community for spousal respite relief."

For the 48-minute visit, you should report 99215 (... physicians typically spend 40 minutes face-to-face with the patient). If the payer downcodes the office visit due to the diagnosis code(s), you should appeal and submit the notes showing that you coded the services based on time spent in counseling and/or coordination of care as allowed by the CPT E/M Services Guidelines.

You Be the Coder and Reader Questions were reviewed by **Marvel Hammer, RN, CPC, CCS-P, CHCO,** owner of MJH Consulting in Denver.