Outpatient Facility Coding Alert

E/M Coding: Know When, How to Justify Time Factor Over Key Components

Survey the visit, documentation to make the correct determination.

Depending on your subspecialty of outpatient facility coding, you may have to factor in evaluation and management (E/M) visits on day-to-day basis. If E/M visits do take up a substantial part of your daily workload, you certainly understand that documentation, above all else, is crucial in working up to the correct code.

Still, physicians and nurse practitioners (NPs) performing the E/M services often make the mistake of not properly assessing for time as an underlying factor in addition to history, examination, and medical decision making (MDM).

Use this comprehensive guide for clear-cut guidelines on when and how to use time as the main factor in your E/M coding.

Don't Get Complacent Using Key Components

"Although ENT physicians are most comfortable with coding their E/M services based on the degree of history, exam, and complexity documented, their coders shouldn't forget the alternate method for choosing a level of service: time," says **Jean Acevedo, LHRM, CPC, CHC, CENTC,** owner of Acevedo Consulting Incorporated in Delray Beach, Florida. What some of these physicians and NPs may not realize is that they may be eligible for greater reimbursement depending on the amount of time allocated for counseling/coordination of care services.

That's why it's important for providers to properly assess numerous different components of time when treating patients. And once these time components are appropriately documented, it's up to the coder to determine whether or not time may override your typical E/M components of history, examination, and MDM.

Grasp the Time Factor Formula

There are numerous elements of a patient's visit a coder needs to take into account when determining the eligibility of time as the primary component of the visit. It's in the process of devising this formula that a coder understands the importance of the clinical documentation process.

Simply put, in order for you to bypass the key E/M components of history, exam and MDM, and use time as the primary factor, the provider must spend greater than 50 percent of the visit performing counseling/coordination of care services. If the counseling/coordination of care services exceed the 50 percent threshold, and the documentation illustrates the total time of the visit, the time spent counseling and/or coordination of care, and what was covered by the counseling/coordination of care, you may determine the E/M code based on CPT®'s typical time estimations. Furthermore, you will use the entire time spent with the patient to determine the appropriate E/M code.

"Total time is counted only as face-to-face time for patients in an outpatient setting," says **Barbara J. Cobuzzi, MBA, CPC, COC, CPC-P, CPC-I, CENTC, CPCO**, AAPC Fellow, vice president at Stark Coding & Consulting LLC, in Shrewsbury, New Jersey. "However, floor time may be counted for the total time for patients in the inpatient setting. Counseling time is face to face time, while coordination of care time can be floor time for inpatient status patients," explains Cobuzzi.

Note: The total time must meet or exceed an E/M code's typical time designation in order to be coded as such. For example, if a provider exceeds the 50 percent threshold for a new patient visit and the total time is 35 minutes, you may code as 99203 (Office or other outpatient visit for the evaluation and management of a new patient ...) since the typical time for a 99203 service is 30 minutes. You should always round down to the nearest time estimation in these situations.

This is where the CPT® manual comes into play. Under most E/M codes, you will find that CPT® provides a time estimation for a typical E/M service. These estimations vary depending on patient setting and code level. For example, code 99201 (Office or other outpatient visit for the evaluation and management of a new patient ...) typically requires 10 minutes for a physician to complete all components of a visit at that level. On the other hand, code 99211 (Office or other outpatient visit for the evaluation and management of an established patient ...) typically requires 5 minutes to achieve the same level of service.

Decide Between Time, Key Components

Using documentation from the patient encounter CPT®'s time estimations, you can confidently determine whether or not you may code a patient's visit using time or the traditional key components. Take a look at this example for a better understanding of how the process works:

Example: An established patient presents to the office with complaints of an infection two days following a breast biopsy. The provider performs a full assessment with an expanded problem focused history, an expanded problem focused exam, and MDM of low complexity. The provider examines the surgical site and prescribes the patient an antibiotic. The provider then spends the next 15 minutes counseling the patient on treating the wound and the importance of following through with the antibiotic treatment. The total encounter lasts 28 minutes.

In order to reach the correct E/M visit code, you want to first calculate the percentage of the patient's coordination of care in respect to the total time of the visit. After dividing 15 minutes into the 28 total minutes, you see that the counseling session took over 50 percent of the entire visit. Since you have met the necessary 50 percent threshold, you may use time as a factor to determine the E/M code. Since this is an established patient, you should consider the options presented by CPT®'s typical time estimations for 99214 (25 minutes) and 99215 (40 minutes). Therefore, you may code this patient's encounter as 99214. If you were to rely exclusively on the key components, you will code the patient's visit as99213.

Use Time as a Factor for Results, Treatment-based Encounters

"Consider the patient seen in the infamous 'test results visit,' for example," says Acevedo. "There is little history and exam documented, but the doctor spends 20 or more minutes during a 35-minute encounter explaining the results of a computerized tomography [CT] scan, the surgery that is recommended, including risks and benefits, and answers all the patient's questions," Acevedo states.

In cases such as these, Acevedo explains that there typically may be a brief history and a problem focused exam, if any; perhaps supporting a 99212 or 99213. However, since time is the controlling factor when greater than 50 percent of an encounter is spent in counseling and care coordination, the number of minutes spent face-to-face with the patient in the office can drive code selection. In this 20 minute counseling scenario, the physician may be able to report 99214.

Keep in mind that the documentation must reflect the total time for the encounter, the time spent counseling and/or coordinating care, and what topics were covered during the patient encounter.