Podcast Transcript

Title: E/M Coding Using Counseling Time
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NCTCFP: Welcome to this podcast sponsored by the National Clinical Training Center for Family Planning. The National Clinical Training Center for Family Planning is one of the training centers funded through the Office of Population Affairs to provide training to enhance the knowledge of family planning staff. Our guest speaker today is Ann Finn from Ann Finn Consulting LLC. Ann is a healthcare reimbursement consultant and a national trainer with many reproductive health care organizations. Welcome, Ann!

Ann Finn: Thank you for the introduction. Welcome to my new listeners, and welcome back if you have listened to other podcasts in our "Coding with Ann" series. We hope these focused coding sessions will provide you with some tips and guidance to enable you to capture and code for your services more quickly and effectively, resulting in both appropriate and timely reimbursement. Today's podcast will focus on outpatient Evaluation and Management or E/M coding using time in a family planning context.

Let's start with a few E/M basics for outpatient coding. To capture medical services, clinical providers use "Current Procedural Terminology," or CPT codes, published by the American Medical Association each year. A subset of these codes include E/M or evaluation and management codes representing the medical service portion of the visit where the clinician evaluates the patient's needs and decides on a plan of care to address the issues at hand. In the outpatient setting, there are 2 types of E/M codes that are commonly used for family planning visits: the preventive visit codes and the problem-focused E/M codes, which we will focus on during this podcast.

Problem-focused E/M codes include the range of codes 99201 through 99205 for a new patient, and 99211 through 99215 for an established patient. These codes are typically selected by the clinical provider when the patient is counseled on contraceptive options or is quick-started on a method, if they're to be tested for an STD, has symptoms that need to be evaluated, or is in the clinic for other related needs.

Determining the correct level of service and code can be confusing and tricky. Under-coding your services may result in an underpayment and over-coding of services can result in payer takebacks and penalties under an audit which are costly in both time and revenue. Remember, if you document everything you do, you should be able to determine and support the codes you bill for the service.

According to CPT guidelines, there are 2 methods to determine the level of the problem- focused E/M codes for the visit.

The first method is based on the documentation of 3 key elements including: the history taken, the exam portion of the visit, and the medical decision making involved to determine a plan of care by the clinician. For new patients, we must use all 3 of the 3 key components, and for established patients we can select the code based on 2 of the 3 key components I just mentioned.

The second method of determining the level of the code includes using time. CPT states, "When counseling and/or coordination of care dominates or is more than 50% of the face-to-face time the clinician spends with the patient in the office or outpatient setting, then time may be considered the key or controlling factor to qualify for a particular level of E/M services." This means that time alone can be used to select a level of care, regardless of the extent of the history, exam, or the medical decision making if the majority of the encounter involves counseling or coordination of care. For E/M services, counseling may include a discussion of contraceptive options, test results, diagnostic or treatment recommendations, prognosis, risks and benefits of management options, instructions, education, compliance, or risk-factor reduction.

According to the Quality Family Planning recommendations, or QFP, patients no longer need to undress and have a full or pelvic exam to start contraception. There are fewer and fewer exams being done and more and more time is being spent counseling the patient during today's family planning visits.

Let's think about a new patient that presents wanting birth control. She has a history and vitals taken and is counseled at length on the different methods of birth control before being quick-started on an oral contraceptive. Let's say the clinician spends 20 of the 30- minute visit counseling the patient on methods, risk reduction and other questions. What code would we select? If we were using the 3 key components to choose the level, we could only code a 99201 or level one visit. Surprised? Well, no physical exam was done beyond vitals and we need to factor in all 3 key components for a new patient so we only reach a level one problem focused code or 99201.

But, now let's use time. Remember the code is based on the total face-to-face time the clinician spent with the patient that was 30 minutes. The 20 minutes or greater than 50% allowed us to use time as the selection method, but is not the number we use to select the code. Based on the 30 minutes face-to-face time, the code for the visit would result in a level 3 or 99203. Remember, the higher the level of the E/M code, the higher the reimbursement typically is. The time requirements are a little different for new patients versus established patients so I've also included a reference chart using time for E/M coding as a tool you can download today.

Let's recap: to use time to select the E/M code, we need to document the total face-to-face time with the clinician, and the time or indicator that shows that greater than 50% of the time was spent counseling and or on coordination of care. Vague statements such as "discussed at length" or "extensive discussion" are too vague and should be avoided. Documentation stating "15 of 20 minutes or 60% of a 20 minute face-to-face visit was spent counseling patient on…" and then add relevant details is sufficient to support the code. The documentation should reflect the nature of the counseling or coordination of care activities. Remember, it doesn't have to be a paragraph long. Just enough details to support the work you have done.

Here are a few more helpful hints.

To determine if a patient is new or established, for CPT guidelines an established patient is one who has received a professional service from the physician or qualified health care professional

or another physician or qualified health care professional of the exact same specialty or subspecialty who belongs to the same group practice within the past three years. A new patient then has had prior services within the past three years.

CPT defines a professional service as "those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services". A patient would still be new, for instance, if the clinician interpreted test results for the patient two years earlier, but had not provided the patient a face-to-face service within the previous three years.

When coding on the basis of time in the outpatient setting, you can count only your face-to-face time with the patient and / or family. This face-to-face time includes not only the time spent counseling, but also the time associated with any history, exam or medical decision-making that you perform. The time you spend reviewing records, or talking with other providers and documenting the encounter without the patient or family present cannot be considered.

Some payers may not allow family time to be counted without the patient present so check with your payers. For instance, Medicare holds fast to its rule that E/M codes must be conducted face-to-face, while some commercial insurers follow CPT, which allows for conversations with the family or family members subsequent to a patient encounter.

Only the time spent by the primary provider such as a physician, physician assistant, or nurse practitioner can be considered in determining the level of service unless your payer states otherwise. There are exceptions. One example is California's Medi-Cal program, which has made a program decision to allow the medical assistant or nurse time to be included in the calculation since they participate in the contraceptive counseling. Typically, time spent with the patient by other members of your staff such as nurses and medical assistants cannot be factored into your face-to-face time for E/M calculation purposes. Check with your different payers to ensure that you follow and understand their guidelines.

While it is not necessary to document a detailed account of the whole discussion, you should identify the major areas of discussion. For example, "counseled patient regarding all contraceptive options before patient decided on an IUD as her method" and make sure your note is thorough enough to justify the amount of time reported.

Get in the habit of glancing at your watch before you enter the exam room, or place a clock in your exam room on the wall behind the patient, and note your start and end time. You can casually glance at the time without the patient being aware of it. Understanding the rules related to time-based coding will not only help you obtain proper payment but also allow you to spend the time necessary to help your patients meet their treatment goals.

Electronic health records or EHR's with E/M codes built into templates can result in inaccurate coding based on the documentation of the particular visit. Always review your code selection before submitting to a payer for reimbursement.

Preventive codes, or the codes 99381-99397, are based on a patient's age, whether they are new or established to the practice, and include counseling in their definition. Time is not used for selecting this set of E/M codes.

Remember, both methods we discussed today of using either the 3 key components or time may be used to determine the level of the problem-focused E/M codes based on the documentation,

but family planning visits are counseling intensive and using time to select the code may often support a higher code than by using the 3 key component calculations for billing and reimbursement. Code some visits both ways and see the difference. I really encourage you to use time when possible. Thank you for joining us today.

NCTCFP: And thank you, Ann, for this information. For more training information and resources on coding in family planning settings, please visit the National Training Centers' website at www.fpntc.org or call the National Clinical Training Center for Family Planning at 1-866-91-CTCFP, that's 1-866-912-8237. Thanks for joining us.