Tulane University Medical Group

Outpatient Time-Based Codes
This education is Part 5 of a 6-part series on documenting and selecting the level of service for outpatient visits.

Part 1: Overview of Basic Principles
Part 2: Documenting a History
Part 3: Documenting an Exam
Part 4: Documenting Medical Decision Making

**Part 5: Time-Based Codes**
Part 6: Billing E/M Services in a Teaching Setting

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Purpose of this presentation:

- To provide a review of the documentation guidelines for outpatient time-based codes.
- To provide documentation examples
- To provide CPT average times for codes 99201-99205, 99211-99215, 99241-99245
- To assist physicians in determining whether a time-based code is appropriate for the service provided

What Do the Documentation Guidelines Say Regarding Time-Based Codes?

- In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.
- Documentation Guideline: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.
  

Can this visit be billed as a time-based service?

- “I saw the patient for a severe exacerbation of rheumatoid arthritis. I spent 25 minutes counseling the patient about her condition”
  ◊ No. Total time and time spent in counseling must be documented to bill a time-based code.
  ◊ The counseling documentation was not detailed enough.

When and how often are Time-Based Codes Appropriate?

- Time based coding is an option for a provider if the patient’s situation requires counseling. Time based codes are not to be used to avoid documenting E/M key components.
- It is estimated (Medicare Part B Newsletter excerpt) that 20% of patient encounters might be counseling encounters as opposed to a typical E/M (HX-EX-MDM) encounter.

What elements must be documented?

- **Time:** The documentation must clearly state the total time of the visit and that counseling comprised more than 50% of the visit.

- **Content of Counseling:** The note must provide some detail of the counseling that establishes and supports medical necessity for the service.
**Documenting the Time-Element**

- There are two ways to document time for a time-based code:
  - Document total time of visit in minutes and total time of counseling in minutes
  - OR
  - Document total time of visit in minutes and state that over 50% of total time was spent in counseling the patient.

**Examples of time element documentation**

- I met with the patient for 20 minutes and counseled her for over 50% of that time.
- The office visit was 25 minutes and 15 minutes were spent counseling the patient.

**Documenting Counseling Element**

- The note must reflect what was discussed with the patient and/or family
  - ◊ It must be patient-specific
  - ◊ Use of “canned” or template notes is discouraged as they may not support medical necessity

<table>
<thead>
<tr>
<th>What topics are considered counseling?</th>
<th>What cannot be considered counseling?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Discussion of recommended diagnostic studies</td>
<td></td>
</tr>
<tr>
<td>- Test Results</td>
<td></td>
</tr>
<tr>
<td>- Discussing prognosis</td>
<td></td>
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<tr>
<td>- Treatment Options</td>
<td></td>
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<tr>
<td>- Counseling on Risk Factor</td>
<td></td>
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<tr>
<td>- Instructions to Patient and/or Family</td>
<td></td>
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<tr>
<td>- Patient Family Education</td>
<td></td>
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<tr>
<td>- Time spent with the patient talking about issues not related to treatment.</td>
<td></td>
</tr>
<tr>
<td>- Resident or other Staff time</td>
<td></td>
</tr>
<tr>
<td>- Non-face-to-face time</td>
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</tr>
</tbody>
</table>

**Examples of counseling documentation**

- “Spoke with patient regarding long-term outlook for insulin-dependent diabetes including lifestyle changes, dietary restrictions and importance of compliance with treatment.”
- “Responded to patient’s questions regarding quality of life issues including pain management, living will, and hospice care.”

**How much documentation is enough?**

When coding based on time, *the documentation of the counseling must support medical necessity*. Use of a template to document counseling is not advised unless the template allows for detailed documentation of counseling.

When coding based on time, any detail that can be included (patient’s questions, family questions, specifics about diagnosis, treatment options, risk reduction factors) will help to support medical necessity.

*See Medicare Part B Newsletter comments on use of templates*
Examples of time-based code documentation:

“I spent 40 minutes with the patient and over 50% of the time was spent in counseling the patient on the pros and cons of chemotherapy alone or chemotherapy and radiation.”

“I spent 25 minutes with the patient and spouse. 15 minutes of discussion regarding accommodations to the patient’s conditions that would assist in the resumption of daily activity.”

Documentation doesn’t have to be “Gone With The Wind,” but must be detailed enough to support Medical Necessity.

CPT TIMES FOR Outpatient E/M Services

<table>
<thead>
<tr>
<th>New Patients</th>
<th>Established Patients</th>
<th>Initial Consults</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 10 minutes</td>
<td>99211 5 minutes</td>
<td>99241 15 minutes</td>
</tr>
<tr>
<td>99202 20 minutes</td>
<td>99212 10 minutes</td>
<td>99242 30 minutes</td>
</tr>
<tr>
<td>99203 30 minutes</td>
<td>99213 15 minutes</td>
<td>99243 40 minutes</td>
</tr>
<tr>
<td>99204 45 minutes</td>
<td>99214 25 minutes</td>
<td>99244 60 minutes</td>
</tr>
<tr>
<td>99205 60 minutes</td>
<td>99215 40 minutes</td>
<td>99245 80 minutes</td>
</tr>
</tbody>
</table>

Sources Cited

- **Know the rules when billing E/M visits based on time.** Excerpt from *Medicare Part B News*, July 9, 2001, pages 5-6
  - Documentation Guidelines
Know the rules when billing E/M visits based on time

Consider billing for more of your common E/M visits based on time. Billing professionals say roughly one in every five E/M services should be billed this way but few doctors take advantage.

“I think some physicians don’t totally understand the [time-based billing] option. Most physicians don’t think of their work as time-based, and so they don’t realize how much time they actually spend on each patient visit,” says Dalrona Harrison, billing manager for Via Christi Medical Center, Wichita, Kan.

But be forewarned. Don’t get carried away. Not everyone agrees that time-based billing is underutilized. Some say doctors who misunderstand the rules often try to count time they spend with patients that shouldn’t be included when choosing the appropriate level of service.

Using time as the deciding factor when billing for an E/M service – when done appropriately, for services dominated by face-to-face counseling – can significantly spike the level of service billed, Harrison says. Example: A physician spends 30 minutes of a 45 minute visit going over test results with a patient and counseling him on treatment options. You can bill a 99214 if you code based on that face-to-face time (using the times included in the CPT definition of E/M codes, 25 minutes for a 99214). But you may only meet the criteria for a 99212 if you code the visit based on the history, examination and medical decision-making elements, Harrison notes.

“If that patient’s problem is not worsening, for instance, your level of medical decision-making is often pulled down” if the claim is subjected to an audit, Harrison says. And for this type of established-patient visit, focused on counseling, doctors rarely take down a new detailed history, she notes. TIP: Encourage doctors in your practice to consider coding based on time by pointing out the effect it can have on the bottom line, suggests Becky McDowell, Aurora Health Center, Fon du Lac, Wis. “Give them a real example. Say, ‘If you code this visit on point system, you’ll have a level-2, but billing with time, you’ll have a level-4,’” she says.

Harrison says she tells doctors “If you realize you’ve been in the room longer than normal for that exam, take a peek at your watch” and then decide whether it may be advantageous to code the visit based on time. TIP: Include time-based billing as an option on your fee ticket or superbill, suggests Dianne Wilkinson, compliance and coding officer, MedSouth Practice Consultants, Dyersburg, Tenn. “If the fee ticket is not structured in such a way as to give [time] as an option, [doctors] are going to forget,” she says.

You need to make sure doctors understand what requirements need to be met to bill based on time. Some say doctors can get carried away by thinking any time they spend with patients can be counted toward a high level of code. “What I find, actually, is that there is a lot of time doctors are spending with patients that they want to count that shouldn’t be counted,” says Cindy Parma, Coding Strategies, Dallas, Ga. “For a doctor to sit and spend 30 minutes doing face-to-face counseling with a patient, I’d like to sit down and find out what [specifically] they were talking about,” she says.

You cannot count time spent talking with a patient about issues not related to his or her treatment, or time your staff spends talking with the patients, she points out.

What you can count: talking about recommended diagnostic studies; talking about test results; discussing a patient’s prognosis; counseling on risk factor reduction; giving the patient instructions including follow-up management; or patient and family education, Parma says.

To justify a code you bill based on time, the practitioner needs to document the total time of the visit, the amount of time spent in face-to-face counseling with the patient, and a note about the content of the patient discussion, according to Medicare’s E/M Documentation Guidelines (both the

Excerpt from *Medicare Part B News*, July 9, 2001, pages 5-6
1995 and 1997 versions). “There’s nothing yet that says you have to document actual in and out times, just the total visit time,” Harrison says. “In other words, you don’t need to document ‘visit started at 4:30 and ended at 5:30,’ but just ‘total visit time of one hour.’”

**TIP:** Be as specific as possible when noting the content of the discussion. Some billing software programs have a “canned” paragraph you can insert about face-to-face counseling, but Parman says she suggests practices steer clear of this kind of generality. “It all comes down to the documentation,” she says.

Parman says that established-patient code 99214, in particular, is often billed based on time but without the proper supporting documentation. She says she suspects this in one reason 99214 is under scrutiny by the HHS Office of the Inspector General (OIG). The OIG in its latest report on Medicare billing errors said 99214 was billed incorrectly in 37% of the cases it examined (PBN 3/21/01). **TIP:** Use your documentation to justify why counseling or patient discussion took the amount of time it did, Wilkinson suggests. For example, “if I had a patient who was slow, or hard of hearing, I’d document that. The rules leave some laxity for the doctor to make his case. But he still needs to make it,” she says. – M. Ingram
Documenting Time-based Codes

Name (Print) __________________________ Date: ______________________ Score: ______

Department/Section: ___________________________ Signature: _____________________

1. The documentation guidelines state time is considered the key or controlling factor when counseling and/or coordination of care dominates more than _____% of the encounter.

2. According to the Medicare Part B Newsletter _______ of patient encounters might be counseling encounters?
   a. 30%   b. 25%   c. 20%   d. 40%

3. What elements must be documented to bill for a time-based code?
   □ a. Total time of visit, total time spent counseling
   □ b. Total time of visit, time spent counseling, content of counseling
   □ c. Total time of visit, time spent counseling, medical decision making
   □ d. Total time of visit, content of counseling

4. The following documentation would support a time-based code. True  False
   I saw the patient for 15 minutes and discussed the need for compliance with treatment plan which includes dietary and physical activity restrictions.

5. What is the CPT average time for a 99245 service (Outpatient Initial Consult)?
   __________________________

6. Write a statement that would document the time element (only – not counseling) for a 99213 level of service (follow-up visit).
   ____________________________________________
   ____________________________________________
   ____________________________________________

7. Does a physician have to document any E/M key components (History, Exam and Medical Decision Making) when billing for a time-based code?
   □ a. No, the guidelines do not require it
   □ b. Yes, the service is still an E/M service that requires some documentation of HX-EX-MDM
   □ c. No, the guidelines do not require it, but some visits may not start out as a time-based code, so some HX-EX-MDM might be documented or the physician may wish to include some key component information in the note.
   □ d. A & C

8. Consider the scope of your practice and choose a condition for which a time-based code may be appropriate. Write a note that would support a time-based code for a 99214 established patient visit.
   ____________________________________________
   ____________________________________________
   ____________________________________________

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Complete quiz, be sure to print name (must be legible), the date, and your department at the top of the form.
SIGN the form (no credit will be given without a signature)
Fax to 504-988-7777 (fax information at top of form, no cover sheet required)