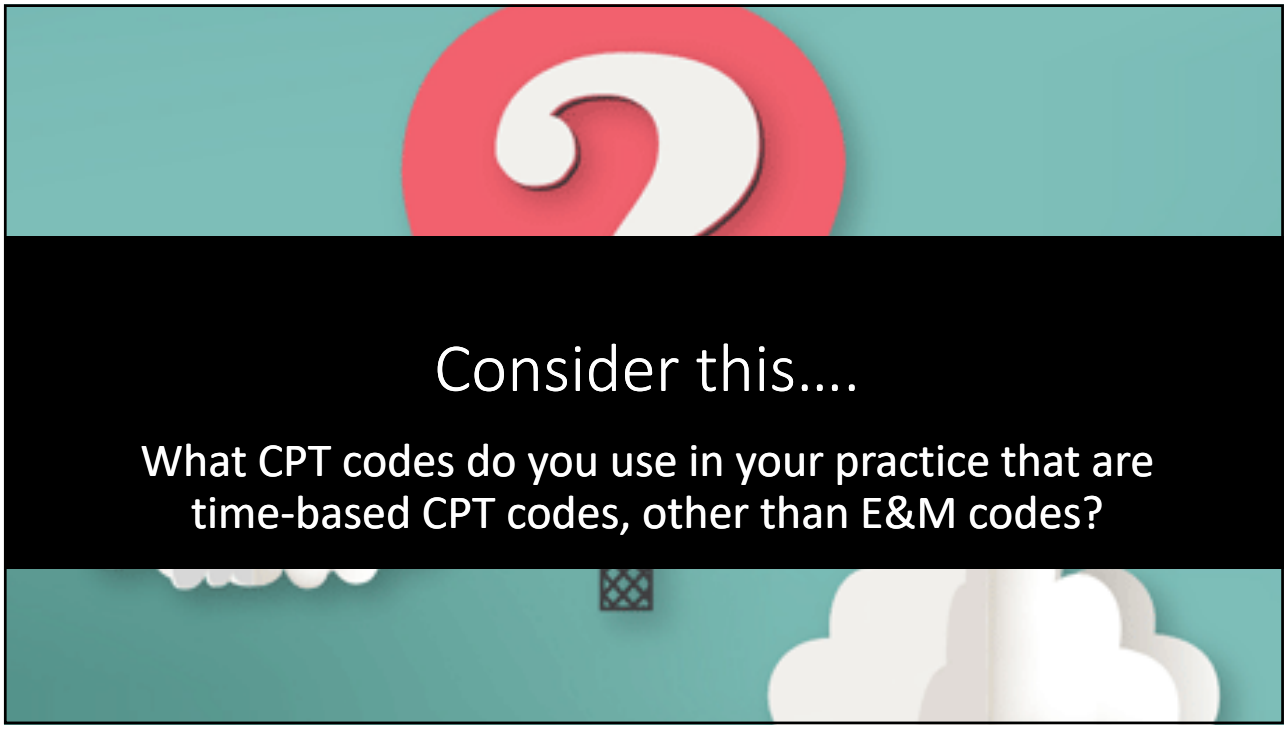
Choreograph the Day with Time-Based Billing

Shannon O. DeConda
CPC, CPC-I, CPMA, CEMC, CEMA, CRTT
President, NAMAS
Partner, DoctorsManagement

1



2

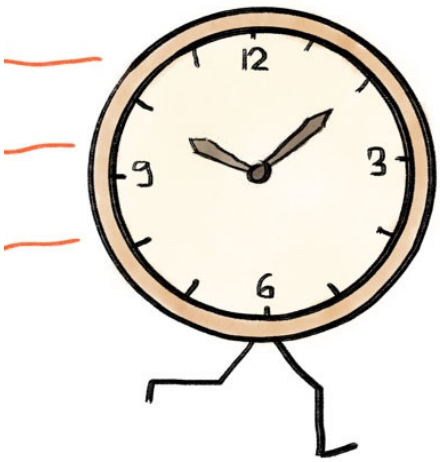
Other CPT Codes

- Some of you may be providing:
  - Psychotherapy
  - Physical therapy
  - Counseling for behavioral health risk improvement

3

In These Instances

- The following time concepts must be considered:
- Midpoint – a unit of time is attained when the midpoint is passed
- Threshold - When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used
- The conundrum – Neither CPT or CMS clearly identified which concept should be used when E&M time falls between two levels.



4


Time in the E&M Encounter

5


Time-Based E&M Services
Time for office-based encounters can be counted regardless of whether the providers is face to face with the patient or not.
The validating component of whether the service is counted is two-fold-
First, what was the provider doing during that time,
Second did the providers document justify the time
The following section will explain the criteria for time-based billing.
In addition, this section will also discuss prolonged services as it would apply to time-based add-on services as well. Let's begin.

6

9 Nurs t Based Service

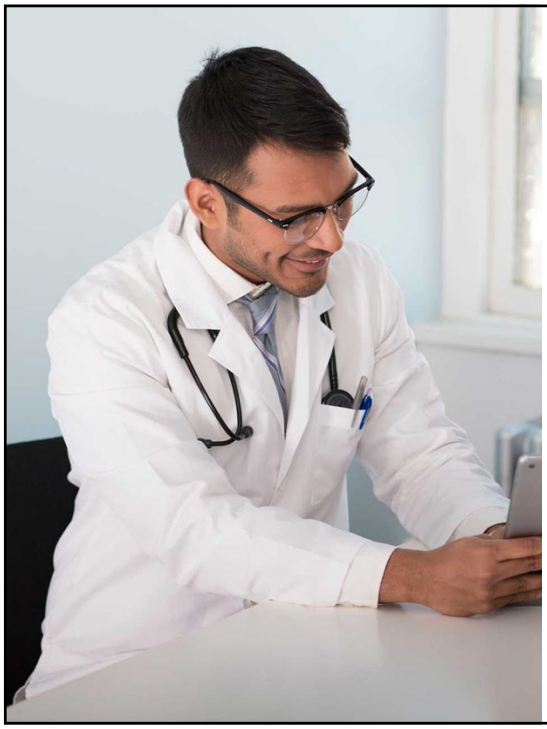
- is not rel for a physician, NP, or PA
- se individu ve a F2F with a patie the visit no less th n a 99202
- NOT a tim d code for this reaso

7

New Patient Office Visits	Total Time on the Day of the Visit	Established Patient Office Visits	Total Time on the Day of the Visit
99201	Deleted in 2021	99211	N/A
99202	15-29 minutes	99212	10-19 minutes
99203	30-44 minutes	99213	20-29 minutes
99204	45-59 minutes	99214	30-39 minutes
99205	60-74 minutes	99215	40-54 minutes

Each CPT has a range of time assigned, and each subsequent CPT code connects to make a rolling time to prevent any gaps. Refer to the chart:

8



Time-Based E&M Services

Notice there are different time ranges for new patients as opposed to established patients.

MDM scoring between new/established patients is the same, but time is different.

This is a straightforward time selection process, especially as opposed to the previous time selection process using typical time.

The AMA rules indicate these minutes are the total minutes on the date of the encounter.

However, the auditor should expect that the provider's documentation would include the total time spent on the date of encounter ONLY.

9

Let's Consider Challenges

What if the provider documents the time in seconds or hours? We could convert that documented time to minutes and accept the recorded documentation.

What if the provider documents that the visit took longer than expected, but does not include a length of time? Unfortunately, a specific amount of time is required to meet time-based requirements and therefore MDM scoring would take precedence.

What if I do not know if the patient is new or established? If you are an internal auditor, you should try to research this answer. However, defaulting to the lower bill is the cautious answer and therefore established. The provider should be educated on the importance of including this information.

10

The provider documented that a total of 46 minutes was spent in the room with the new patient. What level of service would the encounter be, and what advice would you as the auditor give to this provider?

Level 4, however the provider should be reminded that the rules allow for counting total time on the date of the encounter- not only face-to-face in room time.

11

The provider documented a total of 75 minutes on the date of the encounter. What level of service would the encounter be, and what advice would you as the auditor give to this provider?

The provider documented enough total time to account for either a new or established patient. However, with only what is documented here, we are unable to know whether the patient is new or established.

12

Qualification Statement

- When time is being used to report an office visit, the documentation should include sufficient information to support the amount of time reported. This would include a description of the activities personally performed by the provider on the date of the face-to-face visit.
- It is NOT enough for the provider to merely state they spent XX minutes

13

Qualification Statement

- The following is a list of activities as defined by the AMA and approved by CMS the physician or QHP can provide on the day of the visit and include in their calculation of total time:
  - preparing to see the patient (e.g., review of tests)
  - obtaining and/or reviewing separately obtained history
  - performing a medically appropriate examination and/or evaluation
  - counseling and educating the patient/family/caregiver
  - ordering medications, tests, or procedures
  - referring and communicating with other health care professionals (when not separately reported)
  - documenting clinical information in the electronic or other health record
  - independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - care coordination (not separately reported)
- There is no need for a provider to have listed each of these components and the time associated with each. Furthermore, the provider's qualification statement does not micro-analyze their visit time. What it does need to do is “justify” and qualify rationally the amount of time of the encounter.

14

15

Today the total time spent included in excess of 20 minutes. Time included reviewing prior notes, labs, face-to-face visit with the patient, documenting the note, and placing follow up lab orders.

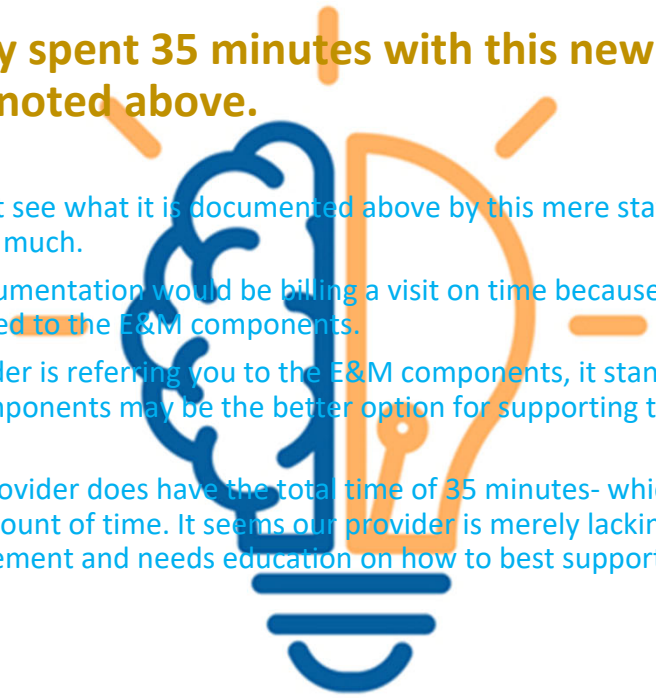
Most auditors, and carriers are no exception, do not like to accept time statements that include phrases such as in excess, or time spent was greater than.

However, there is no rule stating they are inappropriate forms of documentation. Best practice is to refrain from use. When auditing their use- it is best to give the lowest credit for them.

In this example, no more than 20 minutes of time credit should be given. The provider does give quantification of what the time was spent doing, and the time does seem reasonable and purposeful. 99213

16

I personally spent 35 minutes with this new patient as noted above.



While we cannot see what it is documented above by this mere statement, it really does not matter much.

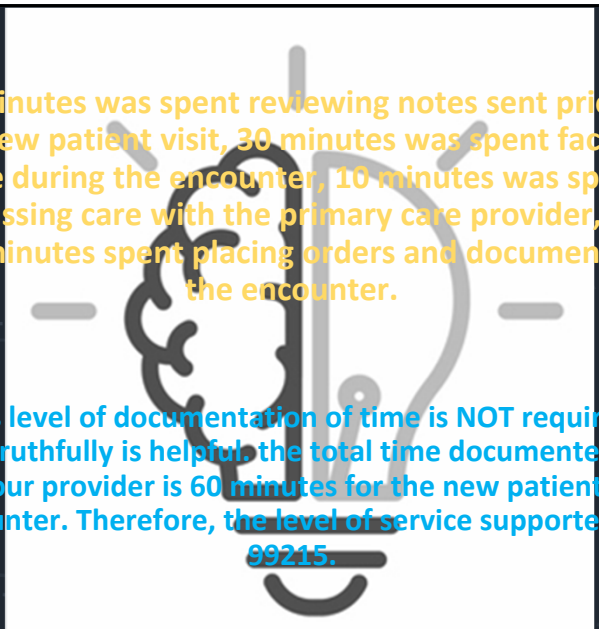
Time-based documentation would be billing a visit on time because time is the best option as opposed to the E&M components.

When the provider is referring you to the E&M components, it stands to reason that the key components may be the better option for supporting the level of service.

However, the provider does have the total time of 35 minutes- which is a considerable amount of time. It seems our provider is merely lacking a supporting time-based statement and needs education on how to best support time services.

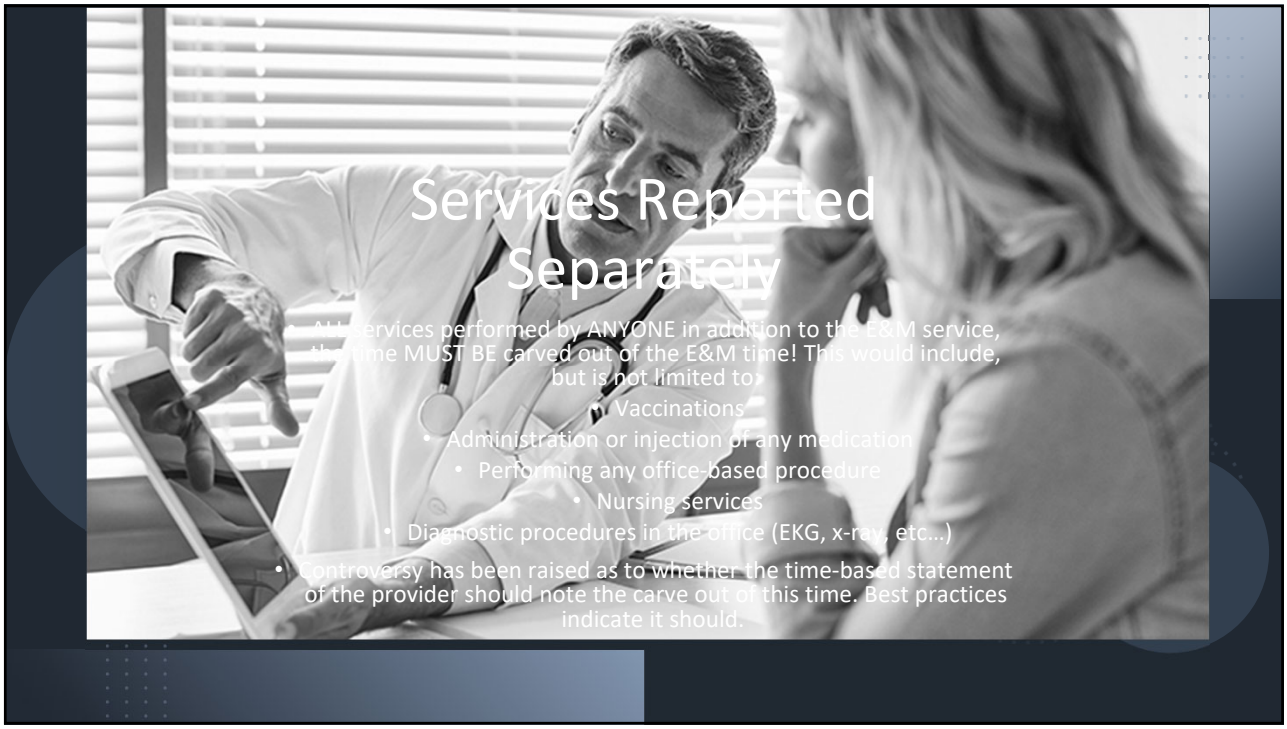
17

10 minutes was spent reviewing notes sent prior to the new patient visit, 30 minutes was spent face-to-face during the encounter, 10 minutes was spent discussing care with the primary care provider, and 10 minutes spent placing orders and documenting the encounter.



This level of documentation of time is NOT required, but truthfully is helpful. the total time documented by our provider is 60 minutes for the new patient encounter. Therefore, the level of service supported is a 99215.

18



19

Carve Out Statement

- The best way to support time when multiple services are performed is to include a carve out statement
- A carve out statement indicates that the encounter was billed based on time, but that procedures were not included in the total time
- Example:
  - Total time included 46 minutes on the date of the encounter which included time reviewing previous records, face to face time, documenting and placing orders. This time did not include any ancillary staff or diagnostic service time.

20

Prolonged Services in the Office and Other Outpatient Setting

- We have two codes for prolonged services.
- The first code was set forth by the AMA CPT code set, 99417 and the second of course by CMS as distinguished by the tell-tell G code prefix of the code, G2212.
- AMA's CPT code 99417 defines the service as "Prolonged office or other outpatient evaluation and management service(s) beyond the total time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes."
- The key point in the AMA's definition is the phrase "beyond the total time of" indicating that as soon as we reached an E&M level, we can now append the prolonged services code in addition to that level of service.

21

Total Duration of New Patient or Other office or Other Outpatient Services (use with 99205)	**Code(s)**
Less than 75 minutes	Not reported separately
75-89 minutes	99205 x 1 and 99417 x 1
90-104 minutes	99205 x 1 and 99417 x 2
105 minutes or more	99205 x 1 and 99417 x 3 or more for each additional 15 minutes

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	**Code(s)**
Less than 55 minutes	Not reported separately
55-69 minutes	99215 x 1 and 99417 x 1
70 -84 minutes	99215 x 1 and 99417 x 2
85 or more	99215 x 1 and 99417 x 3 or more for each additional 15 minutes

22

CMS & Prolonged Services

- CMS disagreed with the AMA interpretation.
- Time-based services indicate that a 99215 is 40-54. CMS's interpretation differs from AMA in that CMS is stating the 99215 obligation is not fulfilled until 54 minutes has been completed, and THEN we have added on our prolonged time requirement.
- G2212's description is "Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)."

23

CMS & Prolonged Services

Prolonged Office/Outpatient E/M Visit Reporting - New Patient

CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99205 x 1 and G2212 x 3 or more for each additional 15 minutes.	119 or more

*Total time is the sum of all time, with and without direct patient contact and including prolonged time, spent by the reporting practitioner on the date of service of the visit.

Proposed Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

CPT Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84- 98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes.	99 or more

*Total time is the sum of all time, with and without direct patient contact and including prolonged time, spent by the reporting practitioner on the date of service of the visit.

24

Case Scenario

HPI: Mr. Smith was working for a sick visit. He complains of right ear pain, cough, sore throat, slight photophobia, muscle aches, chills, subjective fever for two days. Influenza screen in the office today is negative. Denies known allergies.

Exam: WDWN, normocephalic, atraumatic. Sclera non-icteric, conjunctiva clear. Bilateral TM's clear, no deformity. Throat is raw. Neck is supple with no gross deformity. Patient is alert, cooperative and voice is clear.

Assessment: Pharyngitis, viral URI

Plan: We discussed this is likely viral in etiology, but he feels "miserable," so he was injected with 1-gram Rocephin and a dex combo injection. If his symptoms persist and the sore throat continues to be a problem over the next few days, he should fill the Amoxil prescription.

Carol Marcum, ARNP (electronically signed 1/30/2021 13:15)

Addendum: 1/30/2021 14:20 – The patient's wife phoned the office stating the patient is having an allergic reaction with generalized itching. Admits swollen eyes and swollen lips. He was instructed to take 50 mg of Benadryl. (Carol Marcum, ARNP)

Addendum: 15:15 – The wife called again. Patient is still having symptoms of swelling, but denies shortness of breath, dyspnea, wheezing, throat or tongue swelling or throat discomfort. He was instructed to take another 50 mg of Benadryl. A few minutes later, the patient's wife sent me a photo electronically which indicated marked swelling of his lips. I instructed the patient and his wife to proceed to Bay Medical ED. I called the

triage nurse, Mary Smith and notified her of the situation. A copy of today's note was faxed to the ED triage fax. Mary will notify me once the patient arrives.

Face-to-face visit: 15 minutes

Time on the phone with the wife and the ED: 30 minutes

(Carol Smith, ARNP)

What level of office visit E/M is supported in this documentation? _____

Rationale:
99215. The total time documented for the date of the face-to-face visit is 45 minutes. Based on the CPT code description, 40-54 minutes supports 99215.

25

Case Scenario

Chief Complaint: Knee pain
The patient returns for follow-up of right knee pain. The pain is rated as an 8/10 today and is beginning to impact the patient's ADL. This is further compromised by a new onset of pain in the left hip. The hip pain is 10/10 today and limits her ability to get up and down, pivot, and bending over is not an option at this time. The hip has no trauma or injury, and she has not had a history of hip issues in the past.

She notes radiation of pain, mild swelling in the knee, but no noted edema.

Medical history: Diabetes, hyperlipidemia, depression
Social history: admitted social drinker and smoker
Family History: Non-contributing

Exam: Well appearing, agitated patient who is alert and oriented
Cardio: Good pedal pulses with mild edema noted in the right lower extremity
Knee: painful extension and palpation, but a bit more range of motion since last injection
Hip: Does not appear to be any dislocation but does have decreased strength

Assessment & Plan:
OA of the knee
Hip pain- new onset

We will proceed with knee injection today to hopefully provide some relief. As to the hip, I am going to give her some hydrocodone to see if we can alleviate any aggravating factors from the knee. If we do not, then we will proceed with more aggressive diagnostic workup of the hip.

Total time spent on the date of the encounter is 75 minutes for pre-visit review time, in office counseling/coordination of care, and post-visit work.
Services report; 99215, 99417 x 2

What should the auditor's findings be?

Time may be used as the defining component for the level of service; however, based on the context of the E&M encounter and the lack of details within the time-based statement, the total time is not supported.

The auditor should note that while 75 minutes may be billed, the documentation should identify the medical need for a 75-minute encounter.

26


namas
national alliance of medical auditing specialists
Contact me anytime for
Questions,
feedback, or if we can help with audits.
sdeconda@namas.co
877-418-5564 | namas@namas.co

27