AHS's Headache Coding Corner

- **A user-friendly guide to CPT and ICD coding**

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Part 4 - Counseling and Coordination of Care

This section of the Coding Corner will be dedicated to a brief review of Time, Counseling, and Coordination of Care. Although this part of the CPT Guidelines has been referenced in the preceding segments of our AHS Website CPT coding section, there have been a number of questions regarding this CPT component to justify further discussion. Let us begin by defining how these terms are used according to CPT guidelines.

Webster's New Collegiate Dictionary defines Counseling as: "**a**: advice given esp. as a result of consultation **b**: a policy or plan of action or behavior." The CPT nomenclature for E/M coding defines counseling as a discussion with the patient and / or family or other caregiver concerning one or more of the following areas:

- Diagnostic results, impressions, and / or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and / or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

It is important to emphasize that counseling, as defined above, should not be confused with the codes for psychotherapy. Therefore, when it is apparent that the visit is to discuss the patient's clinical course, treatment options, prior studies, the need for further testing, medication issues, or an overview of the patient's disease state including risk management and patient education, it should prompt the physician to consider using counseling (and length of time spent with the patient) as the key determination for the level of E/M service. In Headache Medicine, the initial patient encounter and follow up evaluations commonly include these contributory components. Often, especially for established patient visits, consultation with the patient and/or family may be the main reason for the entire encounter.

Coordination of Care, according to E/M guidelines, refers to time spent arranging and organizing the patient's care with other physicians or providers or even other agencies.

Time is listed in the CPT codebook as average times required for most E/M services. The inclusion of time in CPT "…is done to assist physicians in selecting the most appropriate level of E/M services." The fact that the times mentioned are averages implies that some encounters take more time and others take less time. As stated on page 5 in the CPT 2007 codebook, "…face to face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family." This statement refers to outpatient services including new patient encounters and established patient visits. On the other hand, for physician hospital services, the CPT codebook defines time as "…unit/floor time, which includes the time that the physician is present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time in which the physician establishes and/or reviews the patient's chart, examines the patient, writes notes, and communicates with other professionals and the patient's family." All discussion of "time" in this section of the Coding Corner will be focused on outpatient care.

As stated in earlier sections of the Coding Corner, generally time is not taken into account as a factor for the determination of the level of E/M care for most patient visits in which History, Examination and Medical Decision Making are the key components. However, as implied above, there are circumstances in which time may be the sole determining factor in E/M code selection. When counseling and coordination of care comprises more than 50% of the visit, then time may be used to determine the level of E/M service; or as specifically stated in the CPT codebook, "time is considered the key or controlling factor to qualify for a particular level of E/M service..." This means that when counseling or coordination of care takes more than half of a visit, time is permitted to become the single essential element in defining the level of E/M even if the physician did not take a history, do an examination or document medical decision making. If counseling and/or coordination of care dominates (>50%) the encounter, these contributory components may be used in place of the three key components of E/M. The extent of counseling and /or coordination of care must be documented in the medical record independent of the three key components.

It is specifically stated on page 48 of the 1997 Documentation Guidelines that *"If the physician elects to report the level of service based on counseling and/or coordination of care, the total length 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."* The physician must also *document* that more than 50% of the encounter was spent in these activities. As indicated above, there are "typical" time values which are listed in the CPT codebook for each type of E/M service and level of care. For example:

Initial Patient Visit
- 99202 20 Min
- 99203 30 Min
- 99204 45 Min
- 99205 60 Min

Outpatient Consultation
- 99242 30 Min
- 99243 40 Min
- 99244 60 Min
- 99245 80 Min

Established patient Visit
- 99212 10 Min
- 99213 15 Min
- 99214 25 Min
- 99215 40 Min

At this point, it becomes important to emphasize that there may be cases in which physicians would compare and decide whether to use time and consultation and/or coordination of care or the three key E/M components to determine the level of CPT code. The physician may have the option to select which type of patient encounter would yield the highest level of reimbursement. Frequently, in the reevaluation of an established headache patient, the more common scenario is consultation and/or coordination of care. In Headache Medicine, a counseling visit often has a very positive impact on the quality of patient care and subsequently the quality of the patient's life.

In addition to documenting the components of Counseling, there are important principles of medical record documentation which must be addressed for CPT compliance. The guidelines

emphasize that this is especially true if time becomes the determining E/M factor of the patient encounter.

The medical record should be complete and legible
The date of the encounter should be on each note
The reasons for the encounter should be clearly defined
Define relevant history, physical findings, and prior studies
Discuss the assessment, clinical impression or diagnosis
Past diagnoses should be accessible
Appropriate health risk factors should be identified
Patient's progress (or lack of progress) should be defined
Discussion of the current plan for care
Discussion, if indicated, of changes in treatment
Discussion of the rationale for ordering diagnostic tests
Discussion of the rationale for ordering ancillary services
The CPT code should be supported by documentation
The ICD code should be supported by documentation
The CPT and ICD codes should support one another

The CPT guidelines do direct that the examiner record the number of minutes, or length of time, spent in consultation and/or coordination of care. Many physicians will record the actual time spent with the patient or document the time the face-to-face encounter began and ended. Whether or not time is recorded, the description of counseling or coordination of care provided should be complete enough to substantiate the implied claim that the amount of time spent with the patient would justify the CPT code chosen.

In summary, the CPT coding system and the Documentation Guidelines do provide a format for coding and reimbursement based upon the amount of time physicians spend in patient care. Although consultation and/or coordination of care are accessory components of E/M coding, as outlined in the above discussion, there are encounters when these elements may be considered the sole determining factor in E/M code selection. Therefore, although time is not taken into account as a factor in determining the level of E/M care when the three key components of E/M are the focus of the patient encounter, time (the face-to-face time that the physician spends with the patient and/or family) can determine the level of E/M service when counseling and/or coordination of care dominates greater than 50% of the outpatient encounter. Recording time then may determine the level of E/M regardless of whether the physician performed an extensive H/P and MDM or no H/P and MDM at all. And, as it true for virtually all billing concerns, documentation here is crucial, specifically keeping in mind "typical" time values listed in the CPT codebook for each type of E/M service and each level of care.