CODING Q&A

Coding by Time, for Emergent Care, and for Nurse Practitioner Visits

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Q. How does one determine whether an E/M code can qualify for coding according to time spent? Obviously, any psychiatric counseling would fit the criteria, but what about "teaching" (e.g. how to use an inhaler, how to perform a breast exam), or preventive medicine counseling?
– Question submitted by Dr. Kim, Med7 Urgent Care, CA

A. The key issues on counting counseling or coordination of care toward the E/M code are:

- Counseling and/or coordination of care must take up over 50% of the time that the provider is face-to-face with the patient, and should be medically necessary.
- The content and amount of time spent counseling and total face-to-face time must be documented.
- Only count counseling toward the E/M if it relates to a patient complaint, a disease process, or an abnormal test result.

Counseling for preventive services does not count as counseling time toward a problem-oriented E/M code.

If the visit meets the above criteria, then you use the *total* face-to-face time (not just the time spent in counseling and coordination of care) to determine the appropriate E/M code.

Note 1: In the examples that you noted, e.g., inhaler education, etc., it is extremely unlikely that this counseling would take up over 50% of the face-to-face time.

Note 2: Counseling for preventive medicine services, such as "how to perform a breast exam," are not included in a problem-oriented E/M office visit (99201-99215), but rather would be included in codes for health maintenance physicals (99381-99387).

A rare exception might be if a patient presented with a chief complaint of a breast lump, but in reality the patient was noting normal breast tissue. Then the provider could use the time toward counseling on how to perform a breast exam toward the E/M (99201-99215) if this counseling consumed more than 50% of the face-to-face time of the visit; again, this seems unlikely.

Note 3: In the urgent care setting, if the history, exam, and complexity of medical decision-making are properly documented in the chart, it is quite rare, for the *time* element to raise the code above the E/M level calculated from the actual documentation on the chart.

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Q. Is code 786.59 an emergent care code if the patient has been seen at a clinic, not at a hospital?
– Catherine Danca, Legislative Aide, Illinois State Sen. Pamela J. Althoff

A. The code that you inquire about is an ICD-9 code, which is a code set that is mainly devoted to diagnoses. The code is defined as follows:

- 786.59, "Other chest pain," also known as:
  - discomfort in chest
  - pressure in chest
  - tightness in chest.
- 786.59 *excludes*:
  - pain in breast (611.71)

If you are speaking of whether or not the code would justify the use of the CPT code 99058 (services provided on an

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and your client's attention—among injury management, prevention services, and consulting. Your services would, therefore, be somewhat insulated against, for example, a change in the state's fee schedule.

Likewise, a marketing initiative could include educational programs, one-on-one contact, and e-mail contact. If one area failed to meet expectations, the other two could carry it for a year while the first area was re-invigorated or replaced.

7. *Recognize synergisms*. Be certain that each of your three areas feeds one another. At my company, for example, our educational programs provide us with information for our publications and members, which converts to more consulting clients, which provide us with more insights to share in our educational programs.

   Likewise, the major components of your marketing plan should seldom be a "stand-alone" idea; rather, every idea should be connected to another in order to feed your program in multiple, synergistic ways.

8. *Embrace change-speak*. Embracing change means more than proactively introducing new products and marketing techniques every year. It also means embracing "change-speak" into your vocabulary. You should make judicious use of such words as "new," "modern," and "updated" in your sales and marketing discussions, literature, and personal contacts. You need to *project* constant change and improvement as much as you need to *effect* it.

9. *Keep abreast of technology.* When I established my company some 25 years ago, fax machines were considered cutting-edge technology, and there was no Microsoft Word, Excel, or PowerPoint. Nor was there much of an Internet, e-mail, or cell phones. Yet today, virtually all are central to my professional life each and every day. Looking back, I was probably a bit late in understanding and adopting virtually all of these technological advances.

   The message: stay a step ahead of the posse by keeping abreast of emerging technologies and using them to your advantage.

Status quo—so pervasive in healthcare management—quickly becomes old, tired and counter-productive. It is better to get *beyond* the status quo by asking yourself, "What can I do differently each year?" ■

emergency basis in the office), the answer would depend on the clinical situation.

Based on the definition of the code, it should be used only for patients seen in a physician office. It should not be used in conjunction with emergency department visits or for care rendered during a hospital admission. This code should be used as an add-on code. It is intended to compensate the physician for the interruption in the office schedule when the physician, based on the emergent nature of the patient visit, must leave another patient immediately to render services to the patient in question.

If a patient visits a physician with a chief complaint of chest pain, it is very likely that the physician was called from the care of another patient in order to evaluate the seriousness of the patient's chest pain. Thus, in many cases, CPT code 99058 could be used properly in conjunction with the ICD-9 for chest pain.

Q. Can a nurse practitioner bill under E&M codes?

– *Question submitted by April Knight, claims representative, AMCO Nationwide Insurance Company*

A. Provided that the appropriate state supervisory regulations (if any apply) are followed by the midlevel provider, then it is compliant to use E/M codes (99201-99215) for services rendered by a nurse practitioner or physician assistant. Medicare and some other payors reduce reimbursement by 15% for services rendered by the midlevel provider.

In order to get reimbursement at the full Medicare fee schedule, you may be tempted to bill all midlevel services with the supervising physician listed as the rendering provider.

For Medicare (and some other payors), however, it is important to understand the rules for incident-to billing. Incident-to is defined by Medicare and may not apply to a third-party payor, unless that payor requires the use of incident-to rules. If the midlevel's service meets the incident-to requirements, then the service may be reported using the supervising physician's national provider identification (NPI) number. Medicare will reimburse this service at full Medicare rates, as though the physician personally performed the service.

Under the incident-to rules, however, you may not bill with the physician as the rendering provider unless the visit meets specific criteria. To be considered incident-to, the physician must perform the initial visit for the patient's diagnosis/problem and document a treatment plan that the midlevel provider follows on subsequent visits. The physician must provide direct supervision of each service provided by the midlevel provider. "Direct supervision" does not mean that the physician must actually be present in the same room, but the physician must be present in the office and immediately available to provide assistance and direction to the midlevel provider. ■